ABSTRACT

Adult Suicide: Church Awareness, Support, and Prevention Education

by

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Suicide, a silent killer and mental health issue, has made people reluctant to disclose or discuss it because they felt embarrassed, helpless, and hopeless. The purpose of this project was to identify and recommend suicide education of early warning signs and support in churches, among adults in Kentucky, in order to raise sensitivity to and awareness of adult suicide in local churches. Active ministries are recommended to increase the sensitivity to suicide, provide support groups, and teach suicide prevention to the adult-age population and educators within churches across cultural and diverse communities.

In the literature review, first-hand experiences with suicide, interviews, opinions, and arguments guided and staged the platform for more public awareness and church support in their communities. The literature and this research study confirmed a lack of education and public awareness of suicidal warnings to save lives. The researcher focused primarily on suicide experts David A. Jobes and M. David Rudd. The data analysis gathered from adults who had struggled with suicidal ideations and attempts aligned with Kevin Hines' discussion of his struggles with suicide discussed in his book.

Volunteer participants invited to participate in the research were adults eighteen years of age and older, random, and diverse across all demographics in Kentucky. Participants included adults with suicidal ideations, intents, or behaviors in the past, who had been completely free from any suicidal ideations, intents, or behaviors for at least one

year. Family members and friends, of persons at risk of suicide or who had died from suicide, participated. Mental healthcare professionals, church leaders, and church members participated. Mixed methods consisting of individual interviews, questionnaires, and surveys provided a record of the participants' perspectives and views, including the legitimacy of their views. Out of the eighty-four online Survey Monkey participants, sixty participants completed the surveys and questionnaires. With those sixty participants, an additional five individual interviews conducted privately by the researcher, totaled to sixty-five participants. Participation in the research study resulted in a 73.03% completion rate.

This study revealed a lack of awareness of suicide prevention strategies--spiritual or otherwise--among church leaders and church members. Suicide, a growing trend in the Commonwealth of Kentucky, needed to be addressed. This issue challenged churches to establish education and support ministries to serve the needs of people at risk of suicide with sensitivity, encouragement, and love.

Adult Suicide:
Church Awareness, Support, and Prevention Education

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by

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TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

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Total honor and praise to God with gratitude and thankfulness for leading me to and walking me through this Doctor of Ministry journey. I look forward to my next assignment, as you continue to bless me and expand my territory. I love you, Lord!

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I pray that God blesses the church leaders and churches to respond favorably to my research recommendations and develop an increased awareness, support, and prevention education to help curb the rising trend of suicides by saving the lives of those struggling with suicide.

~ Proverbs 3:5-6 and Philippians 4:13 ~

CHAPTER 1

NATURE OF THE PROJECT

Overview of the Chapter

Chapter 1 provides the framework for bringing more awareness about adult suicide to local churches. I provide a rationale for this project evolving from research supported by personal and professional experience. The overview of the research project includes the research design, purpose statement, research questions, participants, and methods for data collection and analysis. In addition, themes of the literature review and contextual factors are identified. Further discussion of the anticipated project results establishes the importance for and impact of this dissertation on the practice of ministry.

Personal Introduction

From my experience as a Chaplain in a psychiatric and recovery hospital, and supported by the statistics, I concluded that suicide is a silent killer and a mental health issue that people are reluctant to disclose or discuss because they feel embarrassed, helpless, and hopeless. UL Health – Peace Hospital, a psychiatric hospital where I was employed, did not offer mandatory spiritually oriented treatment when a suicidal patient is admitted. Moreover, I have not located any established ministry that targets suicidal adults within my immediate geographic area. Furthermore, informal conversation with clergy colleagues and local church leaders reveals a lack of awareness about suicide prevention strategies – spiritual or otherwise -- among these church leaders, even though suicide is a growing reality in the Commonwealth of Kentucky in general, and among adult congregants in particular, that needs to be addressed.

Church leaders and churches are challenged to establish ways and create ministries to serve the needs of those struggling with suicidal ideations through support, encouragement, and love. I find that churches lack a great need for anonymous support groups for suicidal adults in a Christian-based environment based on the structure and likeness of Alcohol Anonymous and Narcotics Anonymous meetings and groups. These support groups provide spaces for people struggling with suicide to have their voices heard and provide worth and value to their lives. The church can offer this space for those in the world searching for the help and the understanding people need when they struggle with thoughts and attempts to end their life.

Suicidal ideations, attempts, and deaths do not discriminate between faith or non-faith traditions, race, class, gender, or sex. My concern is that many attempted suicides do result in deaths that could have been avoided if the despondent suicidal person had given some intervention a chance to work. Statistics, nationally and statewide, show a growing trend of people who turn to suicide to terminate their lives. Because of these factors, I want to research and identify the underlying causes of suicide in order to intervene early and help heal the causes with not only medical, but also with spirituality sessions added to inpatient and outpatient treatment plans for each patient.

Currently, spiritual interventions are not a standardized component of suicide interventions in hospital settings. Patients can choose to speak to a Chaplain or refuse a visit by a Chaplain. Michael Hogan, co-leader of the Clinical Care and Intervention Task Force, and Julie Goldstein Grumet, director of health and behavioral health initiatives at the Suicide Prevention Resource Center in Washington, D.C., wrote a Health Affairs article on suicide prevention. They proposed that a need for excellent support exists

during care transitions for people at risk of suicide. "Up to 70 percent of patients who leave the ED [emergency department] after a suicide attempt never attend their first follow-up appointment" (Hogan and Goldstein Grumet 1088). "The time period following discharge from inpatient psychiatry and emergency department (ED) treatment is one of heightened risk for repeat suicide attempts for patients. Evidence reported in academic literature shows that follow-up contacts might reduce suicide risk. These caring contacts with high-risk individuals have been demonstrated to be effective in reducing self-harm and suicide" (Luxton et al. 32). These findings led me to the next component of spiritual interventions.

As the second component of a spiritual intervention, I encourage our churches and church leaders to create active ministries that bring suicide to the attention of our adult-age population and educators within the church and across cultural and diverse communities. Just as Alcoholics Anonymous and Narcotics Anonymous are viable support groups, caring contacts like suicide support groups would become of great value in preventing suicide and suicide attempts. Groups set in a church environment based on a loving, caring, and Christian-based platform could instill value, purpose, and worth to a despairing person's life.

As a Chaplain providing spiritual support and positive encouragement to patients and staff in a psychiatric and addiction recovery hospital, I have had a large number of professional encounters with adults who struggled with suicidal ideations and suicide attempts. They appeared to be hopeless in seeking the help they needed to overcome this mental health issue, as evidenced by numerous returns to the facility seeking help with the suicide struggle. I have even felt more helpless in knowing what to say and how to

help them. Other patients I have visited as a Chaplain did not want to discuss their own suicidal ideation and behaviors. They would talk about alcohol and drug additions; behaviors they used to hide. Now, suicide has become the hidden behavior. I am very concerned that suicide will stay in a dark and unspoken place, while it continues to affect and destroy the lives of our adult population if left unchecked. As a Chaplain, I have witnessed a pattern of other issues that have escalated to being emotional and physical suicidal threats on their own lives. I have talked with people who seem to have escalated to a level of suicide from other problems in their lives. The greatest frustration many family members and close associates face is not knowing how to recognize suicide warning signs before it is too late, and the person is now dead. Caregivers and family members are left behind wondering what they could have done to prevent the death of their loved one, friend, or colleague.

I hope that early suicide prevention intervention with a spiritual component will prevent other associated behaviors such as depression, anger, loneliness, and hopelessness from escalating into suicidal ideations, suicidal attempts, and suicidal deaths. A spiritual component in churches and in lay counseling with church leaders could provide affordable and early interventions for people struggling with suicide and associated behaviors to prevent suicidal thoughts from escalating into suicidal behavior.

Statement of the Problem

Statistics published by the Centers for Disease Control and Prevention (CDC), June 2018, reported that suicide rates in the United States continue to increase. In 2016, suicide was the 10th leading cause of death in the United States. The Healthy People 2020's target was to reduce suicide rates to 10.2 per 100,000 by 2020, yet suicide rates

have steadily increased in recent years. This Data Brief used the most recent data from the National Vital Statistics System (NVSS) to update trends in suicide mortality from 2000 through 2016 (Hedegaard et al., "Suicide Rates"). The American Foundation for Suicide Prevention also reported that suicide is the 10th leading cause of death in the US. In 2017, there were 47,173 Americans who died by suicide along with an estimated 1,300,000 suicide attempts ("Suicide Statistics").

In the state of Kentucky, The American Foundation for Suicide Prevention's 2018 Suicide Facts and Figures by state reported that on average one person dies by suicide every 12 hours. Kentucky placed number 20 in a suicide ranking of all the states in the United States of America. Suicide was the 11th cause of death in Kentucky more than twice as many people die by suicide annually in Kentucky than by homicide. Rate per 100,000 in population was 16.79, which computes to 756 deaths by suicide out of every 100,000 people ("Suicide Facts & Figures: 2018"). More specifically, the Kentucky Cabinet for Health and Family Services/Department for Behavioral Health, Developmental, and Intellectual Disabilities (BH/DID) reported that in the past decade, an average of 669 Kentucky citizens died by suicide annually. Using 2017 data, BH/DID reported that more than three times as many people die by suicide annually in Kentucky than die by homicide; Kentucky's suicide death rate is the sixteenth highest in the nation. They are in agreement with other sources that suicide is the eleventh leading cause of death overall in Kentucky. Suicide is the second leading cause of death for ages 10–34. Suicide is the fourth leading cause of death for ages 35–44. Suicide disproportionately affects Kentucky's senior citizens. Suicide is the ninth leading cause of

death for ages 44-54 and the sixteenth leading cause of death for ages 65 and older ("Suicide Prevention Program").

Based on this empirical foundation, this project recommends that churches establish a ministry of suicide education for early detection of suicidal intent and provision of support for suicidal adults and their families. Next, this project identifies informational resources available to local Kentucky churches so that suicide prevention and intervention can become an important ministry in faith communities.

Purpose of the Project

The purpose of this project was to identify and recommend suicide education of early warning signs and support in churches, among adults in Kentucky, in order to raise sensitivity and awareness of adult suicide in local churches.

Research Questions

The following Research Questions align with my Purpose Statement and guided the research project.

Research Question #1

What information and strategies do mental health care clinicians and family members affected by suicide indicate should be included in education of early warning signs and support to raise sensitivity?

The tools used to collect data for this research question were completed Questionnaires from Mental Health Care Workers, Family Members, and Friends who have been affected by victims of suicide.

Research Question #2

What information and strategies do church leaders and members recommend to be included in an educational ministry for the church in order to raise sensitivity and awareness of adult suicide through support and prevention?

The tools used to collect data for this research question were completed Surveys from Church Leaders and Church Members, and Individual Interviews from Pastors and Clergy.

Research Question #3

What information and strategies do suicidal adults recommend to be included in an educational ministry for churches to raise awareness of adult suicidal behaviors and recognition of warning signs, so the church can initiate or improve support and prevention?

The tools used to collect data for this research question were Suicidal Adult Interviews and completed Questionnaires from Suicidal Adults.

Rationale for the Project

As referenced earlier in this chapter, suicide is a growing phenomenon among the adult population. The local church and her leaders are lagging behind national efforts to offer a safe place for suicide prevention and intervention in order to decrease the number of suicides and suicide attempts among our adult population. When equipped with accurate information about suicide and armed with strategies for early intervention, the church can become a refuge to those who bear the unbearable burden of suicidal ideation. Surrounded by a loving, knowledgeable Christian community, and promoted by church leaders, the local church can become a center for emotional and spiritual hope and

healing to those who struggle with suicidal ideation and intent because prevention is key to begin this life-saving process.

This project has theological importance because the love of God and Jesus' sacrificial love is for everyone, the sinner and the saint. The hopelessness and helplessness displayed by victims of suicide do not make God love them less. God loves us in spite of our behaviors. God's unconditional love must be constant and the foundational basis for showing love, compassion, and support for an alarmingly increasing population of suicidal people. This biblical love for everyone is based on the fact that God's love is consistently narrated throughout Scriptures, for example, Romans 5:8: "But God shows his love for us in that while we were still sinners, Christ died for us (ESV)," and John 3:16: "For God so loved the world, that he gave his only Son, that whoever believes in him should not perish but have eternal life." A Christian theology can provide the love, healing and hope that suicide victims need to bring worth and love into their lives for themselves.

Love, healing, and hope will lay the foundation of Christian support for the recovery of those struggling with suicide. They can regain their place and worth in society and not be looked upon as a forgotten population in society. Support groups created in our churches and safe places in our communities can socially challenge and diminish the stigmas of shame, guilt, and embarrassment of suicide and encourage self-worth, self-love, and self-care. The awareness of suicidal struggles can provide an environment for people to reach out for education and help, instead of hiding and denying their suicidal ideations and behaviors. Also, sermons and messages from the pulpits can communicate awareness of the rising trend of adult suicides that can bring the topic into

people's conversations. Conversation about suicide would become an important tool for educating and reaching people struggling with mental health illnesses in a large venue other than a medical platform.

The social stigma of suicide has put a gag on openly talking about this struggle. Suicide is seen as a weak solution to life issues. If the churches in our society are intentional about helping our brothers and sisters in the struggle, this show of love and support could have a positive impact toward helping those in their struggles. Safe places in the church venue could be an important development to hold conversations regarding the preventions of suicide, as an outreach for families and for those struggling with thoughts and behaviors of suicide.

Definition of Key Terms

Suicide is the death from injury, poisoning, or suffocation with evidence, either implicit or explicit, that the injury was self-inflicted and that the decedent intended to kill himself/herself.

Suicide sensitivity is creation of a stimulus of people's awareness to suicide.

Delimitations

The population I am concerned about is adult men and women, 18 years old and older, who suffer from suicidal ideation, intent, or attempts. My research sample included men and women who had experienced suicidal ideation, intent, or behavior in the past; however, they had been completely free from any suicidal ideations or intents for a minimum of one year. Family members of suicide victims, Church Leaders, and Mental Health professionals are the three groups of suicide experts who were included in my research sample. I limited the number of my sample size for pastoral interviews to

ten church leaders. The geographic location for all my sample groups were in the state of Kentucky, USA. I approached church congregations that had at least 200 members, up to over five thousand.

Review of Relevant Literature

The relevant literature consulted for this project consisted of books, journal articles, and case studies by qualified authors in the fields of suicide and suicide prevention. The resources sought were the most current ones published on the subject matter. The themes addressed were the rising trend of adult suicide, preventative methods to combat the deaths resulting from suicide, and the availability of education teaching the warning signs of suicidal ideations and suicidal attempts.

The literature reviews portrayed statistics gathered from international, national and state-level vital statistics, LifeWay surveys, and professional subject matter experts' case studies, that resulted with proven data supporting that suicide is a rising trend in the world, United States and in Kentucky. Statistics showed that there is an urgent need for healing, as suicide has become one of the top causes of death in the United States, with rates rising across the country.

David A. Jobes developed and empirically validated an approach to working with suicidal clients. M. David Rudd, who worked with clinical personnel and suicidal clients, created an alternative no-harm suicide contract named Commitment to Treatment Statement (CTS) that is a better patient-oriented intervention tool than a safety contract with the patient. Kevin Hines is a suicide survivor who wrote a book about his suicidal ideations and suicide attempt in jumping off the Golden State Bridge in San Francisco. Karen Mason is an author and expert on suicide preventions for pastors, chaplains, and

pastoral counselors. Dr. Paul G. Quinnett, a published author and founder of QPR, worked with suicidal people and survivors of suicide for over thirty-five years. Sally Curtin, Holly Hedegaard, and Margaret Warner analyzed and reported suicide rate statistics. American Foundation for Suicide Prevention, Centers for Disease Control and Prevention, and The National Action Alliance for Suicide Prevention listed the latest generated suicide statistics and suicide prevention methods on their websites.

I researched websites which provided the most recent published statistics and literature on suicide. Future data may be subject to change; the pattern of a rising trend of suicides has been consistent over past years. These life and first-hand experiences with suicide, interviews, opinions, and arguments guided and staged the platform for more public awareness and church support in our communities. The literature supported the lack of education and training for a public awareness of suicidal warnings to save lives. I focused primarily on suicide experts Jobes and Rudd.

Research Methodology

In addition to the relevant literature review, this project used a mixed methods research design. The mixed methods used in data collection for this project were surveys, questionnaires, and personal interviews. Two questionnaires, the *Mental Healthcare Staff Best Practices on Suicide Questionnaire* and the *Family and Friends of Suicidal Victims Questionnaire*, both quantitative methods, were used to collect data for addressing Research Question 1 (RQ1 – "What information and strategies do mental health care clinicians and family members, affected by suicide, indicate should be included in education of early warning signs and support to raise sensitivity?"). The questionnaires were designed by the researcher.

Two surveys, the *Pastoral Education & Knowledge of Suicide Survey* and the *Church Current Suicidal Practices Survey*, quantitative methods, were used to collect data for addressing RQ2 – "What information and strategies do church leaders and members recommend to be included in an educational ministry for the church in order to raise sensitivity to and awareness of adult suicide through support and prevention?" Another qualitative method used to collect data for Research Question 2 was a *Pastoral/Clergy Interview on Suicide*. The surveys and interview questions were designed by the researcher.

The quantitative method used to collect data for this project that addressed RQ3 - "What information and strategies do suicidal adults recommend to be included in ministry and education for churches to raise awareness of suicidal behaviors and recognition of warning signs among adults in Kentucky, so the church can raise sensitivity and awareness of adult suicide through support and prevention?" was a questionnaire, the *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire*. Another qualitative method used, to collect additional information through semi-structured interviews, was the *Suicidal Adult Interview* with those who have been self-harm free of suicidal ideations and/or attempts for at least one year. The questionnaire and interview questions were designed by the researcher.

Type of Research

This project is a pre-intervention research study with a mixed methods design of data collection. The quantitative methods used were surveys and questionnaires. The qualitative methods used were semi-structured interviews. Due to the 2020 COVID-19 pandemic, no physical person-to-person interview sessions were conducted; interviews

instead relied on Facetime, Zoom, or the telephone to observe the government-regulated social distancing requirement between individuals.

Participants

Volunteer participants invited to participate in the research were adults, eighteen years of age and older. Any participant 17 years of age or younger in each group of men and women were disqualified from the research. Age, race/ethnicity, and gender were the demographics selected by the participants. Participants included adults with suicidal ideations, intents, or behaviors in the past, and have been completely free from any suicidal ideations, intents, or behaviors for at least of one year. Volunteer participants included family members and friends of persons who had suicidal ideations, suicide attempts, or died from suicide. Mental health professionals who have worked with suicidal clients, and clergy/church leaders active in ministry in the state of Kentucky were participants in the research. Clergy and Church members participants were diverse and random across all demographics in the state of Kentucky.

Instrumentation

Research Question 1:

The *Mental Healthcare Staff Best Practices on Suicide Questionnaire* and the *Family and Friends of Suicidal Victims Questionnaire* were used to gather suggestions to open-ended questions on best practices for suicide prevention. The questionnaires were designed by the researcher and expertly reviewed by my dissertation coach and a licensed mental health therapist.

Research Question 2:

The *Pastoral Education & Knowledge of Suicide Survey* was used to determine the knowledge and education levels of the church leaders with regard to identifying and ministering to people at risk of suicide.

The *Church Current Suicidal Practices Survey* was used to determine training and support practices currently used by the church. These surveys provided quantitative analysis to identifying academic growth and training materials needed to raise awareness of suicidal warning signs among church clergy and church members. The surveys were designed by the researcher and expertly reviewed by my dissertation coach and a licensed mental health therapist.

The *Pastoral/Clergy Interviews on Suicide* questions dealt with clergy participants' opinions about the best practices for suicide prevention and how they saw the church's answer to the purpose statement and Research Question 2. The qualitative analysis of the *Pastoral/Clergy Interviews on Suicide* was used to provide additional answers to the church's posture on ministering to people at risk of suicide.

Research Question 3:

The *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire* and the *Suicidal Adult Interview* questions were used to gather data from adults struggling with suicide. The interviews and questionnaire represent the voices of people in the struggle of suicide who have been self-harm free of suicidal ideations and attempts for at least one year. This data provided information and strategies that should be included in training materials for churches to raise awareness of suicidal behaviors and recognition of warning signs answering the purpose statement of the project.

Data Collection

Data was collected from purposive samples of the following: selected pastors and church leaders who had at least three years of preaching experience and ministering at a church; mental healthcare workers and family members experienced with people at risk of suicide attempts or completions; family of at-risk adults; and adults at risk of suicide with at least one year free of suicidal ideations and attempts. The surveys and questionnaires were emailed to at least ten individuals in each category across the state of Kentucky. The interviews were semi-structured and consisted of descriptive, ideal position, knowledge, practice, and opinion questions.

Data Analysis

I used mixed method designs of data collection for my pre-intervention research study for this project. The data collected was analyzed through identification and organization by themes/patterns, slippages/disagreements, and silences/omissions.

The *Pastoral Education & Knowledge of Suicide Survey* addressed RQ2; the quantitatively analyzed data identified the need for clergy to acquire more education in how to recognize and minister to people at risk of suicide. The researcher reviewed the surveys to count and compare the number of educated clergies versus those who were not fully trained. Percentages were computed from the numbers acquired. The *Church Current Suicidal Practices Survey* addressed RQ2 and identified either the lack of or the need for more suicide training and support in churches for people struggling with suicide. The researcher reviewed the surveys to count and compare the numbers of suicide-related ministry practices in the church versus those who have none. Percentages are computed from the numbers acquired. The *Pastoral and Clergy Interviews on Suicide* was used to

qualitatively analyze the church's stance on suicide, the lack of support groups for congregants at risk of suicide, and the need for suicide awareness training for the congregation. The interview manuscripts were reviewed and explored several times by the researcher to list and notate similar ideas, statements, themes, and categories along with new ideas in regard to their church's training, awareness, and support of a suicidal victim's needs.

The *Mental Healthcare Staff Best Practices on Suicide Questionnaire*, the *Family and Friends of Suicidal Victims Questionnaire*, and the *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire* were quantitatively analyzed for patterns of best practices of information and strategies to support the development of training materials and support for the church; to learn preventions and heighten the awareness of suicide that was lacking in the church. The researcher reviewed the questionnaires to count and compare recurring answers and new ideas to support training material and support from the church for people at risk of suicide. The data from the *Suicidal Adults Interviews* were qualitatively analyzed for additional information and strategies included in the church's training materials and the support desired that was lacking from the church and church leaders. The researcher reviewed and explored the interview manuscripts several times to list and notate similar ideas, statements, themes, and categories along with new ideas to assist the needs of a suicidal person at risk.

Generalizability

Suicide and its related struggles cross cultural, racial, age, and gender lines. No demographic is excluded. Data collected from persons with personal knowledge of the

subject matter should eliminate biases across faith traditions and non-faith practices. The inclusion of pastors, healthcare professionals, family, and adults at risk offered an important spectrum of experiences. Anyone repeating this study would benefit from hearing what these groups have to say. The voice of the people at risk and in the struggles of suicide are important to be heard and given value in creating interventions that teach and assist in life skills and survival.

Project Overview

Chapter 1 of my pre-intervention project stated the problem and purpose of this project. Its purpose was to identify and recommend suicide education for churches to raise awareness of suicidal behaviors and recognition of warning signs among adults in Kentucky, in order to raise sensitivity and awareness of adult suicide in local churches. Chapter 2 reports on the review of literature relevant to this project. Chapter 3 provides detailed reporting on what was done to answer the Research Questions and why. Chapter 4 reports the data from each research instrument and identifies major findings of the study. Chapter 5 provides a learning report on what the project means for suicidal people, recommending best practices and educational materials for churches to raise awareness of suicidal behaviors and warning signs among adults in Kentucky, so the church can raise sensitivity to the rising trend of suicides among adults through support and prevention.

CHAPTER 2

LITERATURE REVIEW FOR THE PROJECT

Overview of the Chapter

Suicide is a rising trend in the adult population. This trend is evidenced by statistics researched and numbers maintained by numerous entities concerned with the mortality rate of adults by suicide and suicidal attempts. Suicide rates published by the Centers for Disease Control and Prevention (CDC) in June 2018, supported the fact that suicide rates in the United States continue to increase. "Suicide is one of the top causes of death in the U.S., with rates rising across the country. Nearly 45,000 Americans died by suicide in 2016, according to the CDC" ("Suicide Warning Signs"). Kentucky placed number 20th in a suicide ranking of all the states in the United States of America. Suicide was the 11th cause of death in Kentucky. Rate per 100,000 population was 16.79 which meant 756 deaths by suicide in the state. Nationally, the number of deaths by suicide was 44,695 ("Suicide Facts & Figures: 2018"). One factor that may contribute to the absence of any intervention prior to many suicide attempts is a lack of awareness of the warning signs of suicide among friends and family in general, and within the local church in particular. The purpose of this project was to identify and recommend the most effective suicidal educational materials for churches in Kentucky to raise their awareness of suicidal warning signs, so the church through psychoeducation and spiritual/emotional support can raise sensitivity and awareness of the rising trend of suicides among adults.

The literature review is organized as follows: First, the biblical foundations section asks the question if suicide is in the Bible, highlights the discovery of numerous suicides in the Bible, and identifies a biblical remedy for suicidal ideation stressing the

importance of God's love for everyone. Second, the theological foundation illuminates Jesus's ministry with the marginalized, demonized, and those struggling with sickness that neither the victims nor the medical community could heal. Jurgen Moltmann's theology on hope and John Wesley's theology on sickness and healing are shared. Third, the research theme questions answer with relevant literature from the latest statistics acquired from current articles, websites, case studies, along with trusted opinions from recognized experts on suicide, both contemporary and past. The fourth section reviews and examines the literature research design. Chapter 2 ends with a summary of the review literature.

Biblical Foundations

The biblical foundations for this project are based on the fact that God's love is for everyone as narrated throughout the Scriptures. First, this section discusses whether suicide exists in the Bible. Second, it reviews suicides found in the Old Testament. Third, it discusses suicidal ideations in the Old Testament. Next, it explores suicide in the New Testament. Finally, it offers a biblical remedy for suicide: God's love is for everyone. God wants us to encourage and support each other. Philippians 2:1-4 reminds believers to acquire the attitude and heart of Christ toward others. Believers are to have the humility to value others above themselves, like Christ did. The joy found in Christ is being like-minded, having the same love by being one in spirit and in mind. Paul proclaims in 1 Corinthians 12:26, that if one part of the body suffers, then all parts of the body suffer; whereas, when one part is honored, then everyone rejoices together. The beauty of this is that the stronger members of the body are charged with caring for the weaker and more vulnerable members (Keefe 31).

Suicide in the Bible?

Suicide occurred in biblical times as evidenced by events in the Old Testament Scripture. Even though the word "suicide" is not found in the Bible, a commandment of the Mosaic Law referenced that God's people should not commit self-inflicted death. The Old Testament commands, "Thou shalt not kill" (Exod. 20:13 KJV). According to Old Testament scholar Leon Nemoy, this commandment refers to self-inflicted death as well as murder of others (414). "While the suicide of a believer is always an anguished pastoral situation, it takes greater faith not to give up on life and God, and to persevere in what seems to be a living hell" (Wilson 253). Nemoy further explains that it is better for people to preserve their own life in order to repent and come back to God, rather than take their own life. By remaining alive, people have the power to perform various good deeds, such as would make their repentance doubly beneficial. People who have died from suicide can do nothing of the sort; therefore, people may not commit suicide under any circumstances (420).

In the New Testament, 1 Corinthians 6:19-20 instructs believers not to destroy themselves: "Or do you not know that your body is a temple of the Holy Spirit within you, whom you have from God? You are not your own; for you were bought with a price. So glorify God in your bodies (ESV)." Although Paul narrates in a context to flee from sexual immortality, biblical scholars have used this Scripture to reference any bodily harm that does not honor God. Nevertheless, Jesus spoke of life, not bodily hurt, harm, or suicide.

Completed Suicides in the Old Testament

The Old Testament gives witness to six of those suicides that were attempted were completed, ending in death. Robert Barry said, "In the Bible, God never accepted pleas for suicide or to kill out of compassion. Suicide is not tolerated or accepted in the Bible except as the sacrifice of one's life as a means of serving God" (283). Samson defeated the Philistines who imprisoned him by his self-sacrifice of heroism, demonstrating his restored faith in God. Samson was the only one whose motive for suicide was for revenge to bring a crushing defeat to the Philistines, by giving up his life. Samson's self-sacrifice restored him to favor with God. His death showed that he loved God and was willing to die for God (Judg. 16:28-31; Walton and Keener 542; Barry 283).

According to the Scriptures, Saul's popularity was undermined by David's presence. Jealousy and suspicion led Saul into deep depression and he became mentally unbalanced at the end of his life. Critically wounded Saul fell on his own sword to escape further abuse from the Philistines who had already killed his three sons. Saul died lonely and forlorn, killing himself in the battlefield of Mount Gilboa after a crushing defeat by the Philistines. After Saul's armor bearer witnessed Saul's suicide, he also fell upon his sword and died with the king. The armor bearer's act could have been one of honor for King Saul, showing strong proof of his devotion to his master, or his fear of abuse and torture by the Philistines before they also killed him (1 Sam. 31: 1-5, Drane 81; Shemesh 164).

Prophet Ahithophel, ex-counselor and betrayer of King David, was in grave despair over the deception perpetrated around him. The prophet's wisdom and advice

were no longer accepted as sound advice by the people. He went to his home and got his affairs in order and hung himself. Ahithophel must have understood that his life was in jeopardy due to his treason against David who had returned to power. This suicide was a punishment for Ahithophel's act of treason against David, the great king of Israel. Ahithophel is the only suicidal victim in the Bible who had time to arrange his affairs and provide his household instructions prior to killing himself (2 Sam. 17:7, 14, 23; Walton and Keener 542; Barry 283; Shemesh 164).

Abimelech was made king of Shechem where he reigned for three years. Later in a siege, he was critically wounded by a milestone dropped by a woman from a wall on his head. Abimelech instructed his armor bearer to kill him with his sword, so he wouldn't be dishonored by this woman who had crushed his skull with a mile-stone after Abimelech had set the tower she was in on fire. This suicide was seen as a divine punishment for the murders of the seventy sons of his father, Jerubbaal (Judg. 9:53-54; Tenney 4; Barry 283). Zirmi, the fifth king of the northern kingdom, reigned for one single week when he was besieged by Omri. Zirmi decided to commit suicide and burn the king's house with himself inside it. Zimri had assassinated the previous king and his entire family. After suffering a grave military defeat, Zimri avoided capture by burning his palace over his own head to keep his enemies from killing him (1 Kings 16:18-19, Tenney 609, 913; Barry 283).

In these six suicidal stories, their motives varied and the methods of self-inflicted death were diverse. These stories infer that suicide was a justifiable choice in the exceptional, extremely difficult, and hopeless situations these men found themselves (Shemesh 157-67).

In the Old Testament, suicide was sometimes accepted as an appropriate response for the victim to escape situations that he could not overcome. Judges, 1 and 2 Samuel, and 1 Kings describe some of those self-imposed deaths that served to escape evil, avoid shame, dishonor and capture. Each of these suicidal occurrences may be argued to fit with the *noble death* ideal. The ancient world considered suicide when carried out for family, friends, or country a "noble death" (Seeley 83; Neyrey 278, 287). Yet, the tone of these Old Testament passages characterizes these suicides as tragic, based on desperation, and an utter lack of hope. In today's culture, the condemnation of suicide may appear different from the ancient cultural thinking regarding suicide. While Scriptures do not articulate judgment on these suicidal victims, it does lament the loss and the lack of hope that led to the suicides. It is arguable that Scripture or God sees the deaths as noble. God in his mercy "will not bruise a bent reed or put out a smoldering candle" (Isa. 42:3), but neither will God call ending life noble. Suicide was a means of retrieving honor in ancient Mesopotamian thinking, yet in ancient Egypt, suicide was frowned on generally although it was allowed for officials who were facing capital crimes (Walton and Keener 542).

Suicidal Ideations in the Old Testament

Job and the prophet Elijah are examples of adults who struggled with suicidal ideations in their lives. The Bible suggests that Job contemplated suicide but did not make any attempts. Instead, Job placed his trust and faith in God. Although Job had suicidal ideations, he did not hang himself as denoted by his desires narrated in the following Scriptures. Job said, "so that I prefer strangling and death, rather than this body of mine. I despise my life; I would not live forever. Let me

alone; my days have no meaning" (Job 7:15-16). In these two verses, Job weighed his life against death only to express the overwhelming extent of his despair. Job was in grave despair and anguish. Yet, he chose to trust in God and survived to live, showing great faith. Job never transitioned from suicidal ideations to suicide attempts due to his resilience and faith in facing his tragic losses and disappointments. He held on to his integrity against his friends and rejected his wife's advice to take his life. The patience of Job has the sense of steadfast, preserving faith, a commitment not put off by difficulties or obstacles (Cho 227-28; Wilson 61, 252).

The Old Testament prophet Elijah struggled with suicidal ideation. Although the prophet had been successful over the prophets of Baal, he fled for his life from Jezebel's death threats. Elijah fled alone and isolated himself in the wilderness. Elijah had suffered an overwhelming attack of doubt and uncertainty that had a large influence over his life. He wished for death and asked God, in his time of despair, to grant it to him. Instead of death, God, the giver of life, ministered to Elijah by offering him food and sustenance. This food and sustenance symbolized God's power to overcome our afflictions and trials (1Kings 19:2-8; Drane 235; Barry 283). Like Job, Elijah chose to practice great faith in God and survived to live. Trust in a faithful God is what they depended on as they chose life over death. Trusting in God is an important spiritual practice that our churches teach, the Bible supports, and is the preferred option to practice in times of despair, hurt, and hopelessness.

Regarding the experiences of prophets and people like Job, Scripture does not explain why God seemed to hide from them in their deepest needs. Although it

was difficult to see God at work in their lives, personal experiences and acts in history showed evidence of God's mighty acts. These acts assured that those who kept the faith were offered something more significant than what was lost (Drane 236). Trusting in God resulted in life-saving and blessings that Job and Elijah experienced, and not life-ending. Unlike both, if a person is a non-believer in God and is suicidal, then a grave issue is at hand.

David often lamented in Psalms, revealing his despair: "How long, Lord? Will you forget me forever? How long will you hide your face from me? How long must I wrestle with my thoughts and day after day have sorrow in my heart? How long will my enemy triumph over me?" (Ps. 13: 1-2); however, David did not end his life. Instead, David proclaimed to God, "I trust in your unfailing love; my heart rejoices in your salvation. I will sing the Lord's praise, for he has been good to me" (Ps. 13: 5-6). Many more individual and communal laments of shame, deep distress, and despair are narrated in Psalms (Ps. 12, 25, 31, 44). They also contain requests for help from God and expressions of trust and hope in God. John Drane argues that no matter how difficult it was to figure out life's toughest experiences, or how hard it was to see God at work, God was there. Those who sought God diligently had God ultimately revealed to them (238).

Completed Suicide in the New Testament

In the New Testament, the only completed suicide mentioned is that of Judas Iscariot (Matt. 27:3-10; Acts 1:18-20). Tradition says that Judas hung himself from a tree bough that projected over the precipice, a cliff overhanging the valley of Hinnom. Tradition holds that the bough broke due to his weight in the struggles of strangulation, and Judas fell into the valley. The fall crushed and caused his body

to burst (Rice 284). Suicide was considered in Roman tradition a nobler way to die than by being killed by others. Some Jewish people considered it more noble to commit suicide than fall into the hands of torturers or be defiled. However, in Scripture, Judas's act was viewed in a negative light. Hanging was a dishonorable form of suicide (Keener 119). Scripture links Judas's betrayal of Jesus with his suicide. As a first-century honor-shame norm, Judas's hanging was viewed as atonement for his sin of betrayal of Jesus' innocent blood. Judas's suicide resembled the women in antiquity whose suicides were atonement and restoration of one's honor (Kozar 8; Reed 51). Yet, Judas's suicide revealed the gravity of his abandonment of his apostolic call and the betrayal of Jesus Christ.

A Biblical Remedy for Suicide - God's Love is for Everyone

The love of God and Jesus' sacrificial love is for everyone, the sinner and the saint. The hopelessness and helplessness displayed by victims of suicide does not make God love them less. God loves us in spite of our behaviors. God's unconditional love must be constant and the foundational basis for showing love, compassion, and support for an alarmingly increasing population of suicidal people. This biblical love for everyone is based on the fact that God's love is consistently narrated throughout Scriptures. John Drane describes God's love, in Psalm 13:2, like a quiet rest in a divine mother's arms (229).

Two New Testament verses testify to this steadfast love of God: Romans 5:8 and John 3:16: "But God shows his love for us in that while we were still sinners, Christ died for us" (Rom. 5:8), and "For God so loved the world, that he gave his only Son, that whoever believes in him should not perish but have eternal life" (John 3:16). Raymond

E. Brown argues that Paul narrates in Romans that the self-giving of Christ is what love is based on. Christ's sacrifice portrayed a love for people not because they were good, but for people while they were still sinners. Brown explains that Christ's death accomplished salvation, justification, and reconciliation. Brown points out that Paul's narration is a great New Testament explanation of divine love. Christ's divine love portrays a willingness to die for sinners who do not deserve grace (Brown 533, 567).

A Christian theology can provide the love, healing, and hope that suicide victims need to bring worth and love into their lives for themselves. Romans 8:1 is a reminder and remedy that "there is now no condemnation for those who are in Christ Jesus." While Paul narrated that God's love is given for us even as sinners, Jesus Christ's greatest love for us was shown by his painful sacrificial death on the cross for each of us. God's love for all of us in the world is proclaimed and evidenced in John's powerful and well-known Scripture, John 3:16. C. Clifton Black says, "For Paul it is this death that effects reconciliation between God and humanity and makes possible the salvation of humankind" (420). This reconciliation is for all people regardless of a person's circumstances. Salvation is eternally secured because God is faithful, reliable, and trustworthy. God will never fail to fulfill his promises. Paul addressed the Corinthians, a population of Christians who stumbled and struggled with setbacks and sins, yet he assured believers that God would faithfully sustain them and declared that no one could separate them from the love of Christ. God is faithful and committed to protect and preserve his children through to the end when Jesus returns (Storms 45-46).

Theological Foundations

Love, healing, and hope lay the foundation of Christian support for the recovery of those struggling with suicide. A Christian theology can provide the kind of love, healing, and hope that suicide victims need to bring worth and love into their lives. They can regain their place and worth in society and not be looked upon as a forgotten population. The fact that all humanity is made in God's image, *Imago Dei*, implies that all people are of equal value and importance which gives each person worth and dignity. Social relationship differences are resolved by Genesis, saying that all people belong to the same race. Being made in God's image means that people are incomplete without God, as men and women are creations of God. Humanity is intended to be in partnership with God who gives direction and meaning to life; he provides a divine connection that is vitally important to human satisfaction. Communication between God and people was intended to be personal and delightful (Drane 260-61). John Wesley's theology of sickness and healing and Jurgen Moltmann's theological theme of hope are theological concepts that prove helpful in understanding people with suicidal behaviors.

Jesus, throughout his ministry, repeatedly ministered to those who struggled with physical and spiritual health issues. Jesus loved and brought healing to those who desired love and hope, along with mental, emotional, social, and physical healing. Love and healing are two important theological themes practiced by Jesus, and these practices carry the same importance in ministering to suicidal people now. Jesus embraced the woman with the issue of blood, people with demonic spirits; he fed the hungry, and he returned the dead to the living. All of these are examples of those struggling with something they themselves could not heal (Creel 25). Richard E. Creel says, "Jesus gave us hope that evil

and indifference, failure and loss, will not have the last word in history or in our lives" (Creel 34). The church's role in supporting people struggling with suicide is not only important but a responsibility to provide ministry to people in need.

Eschaton

Christianity teaches that the final event in the divine plan and the ultimate Christian hope is about heaven, where the saved believer goes; otherwise, hell is for the wicked and unsaved (Wright 17). N. T. Wright argues that Christian future hope is centered firmly on Jesus' resurrection and a new bodily existence in a newly remade world (41). In the Lord's Prayer, "Thy kingdom come, on earth as in heaven" is one of the most powerful and revolutionary sentences. The first Easter powerfully answered this prayer and it will be answered fully when heaven and earth are recreated in the new Jerusalem (29). Wright explains, "Easter was when Hope in person surprised the whole world by coming forward from the future into the present. The ultimate future hope remains a surprise, partly because we don't know when it will arrive and partly because at present, we have only images and metaphors for it, leaving us to guess that the reality will be far greater, and more surprising" (29).

Believing in the resurrection of Jesus suddenly ceases to be an event in the first century and becomes a matter of rediscovering hope in the twenty-first century. Hope is when you suddenly realize that a different worldview is possible, a worldview where the powerful, the rich, and the unscrupulous do not have the last word after all (75). Wright further explains, "The same worldview shift that is demanded by the resurrection of Jesus is the shift that will enable us to transform the world" (75). The New Testament image of the future hope of the whole cosmos is grounded in Jesus' resurrection. The picture of

the whole world in the future is promised to be under the sovereign and wise rule of the creator God. God's great mercy gives us new birth to a living hope by Jesus' resurrection from the dead. Decay and death of the world will be gone and a new creation born (Wright 107, 271).

It is the resurrected Jesus who calls us to begin living a resurrected life with him right now. Love is at the very heart of the surprise of hope as the resurrection encourages us to hope and enables people to love in a new way. This new love will be from people who have learned more deeply how to hope (288). The eschatological piece that sets all things right is "the truth of the resurrection, turned into prayer, turned into forgiveness and remission of debts, turned into love. It is constantly surprising, constantly full of hope, constantly coming to us from God's future to shape us into the people through whom God can carry out his work in the world" (289).

John Wesley's Theology

John Wesley, a great theologian and minister, set examples of theology for sickness and healing every time he cared for the broken, marginalized, and downtrodden of society, with healing through what Wesley called *faith work by love*. He believed that God still worked miracles, as witnessed in the Bible through Old Testament and New Testament healings. Wesley trusted God to heal in prayers answered, accomplishing the work of God's kingdom in people, the church, and the world. Wesley used prayer as a power tool in his healing ministry (Hiatt 101-02, 107). R. Jeffrey Hiatt acknowledged, from the Gospel of Mark, that "the sick and infirmed not only need their bodies reformed, but also need their spirits renewed. As Jesus fulfilled Isaiah 53:4 and became the healing balm, so now the church is commissioned to be the wounded healer to the nations" (102).

This Wesleyan perspective, derived from John Wesley's own personal practice of healing, demonstrated an ability to meet the needs for social wholeness in his society. Our society today would benefit from these Wesleyan practices, as societies continue to lack significant health care and social wholeness. Wesley's witness was for the church to join in a healing ministry to transform the communities by the power of God from sickness to healing. Wesley gave proofs, in his own healing ministry, that the divine empowerment of God and Jesus's ministry healed physical diseases and cured souls of their sins (Hiatt 105-07).

At the heart of Methodism was a theology of optimistic hope, deeply rooted in moral transformation. The preachers emphasized to their listeners: autonomy and freedom through faith, divine grace, and social equality. To be Christian, people must experience extensive renewal of the *Imago Dei*. The renewal of one's moral image, knowledge of being made in the image of God, is foundational, sanctifying intentions and affections, walking in the holy love of God and love for our neighbor (Perry and Easley 65, 191). The practical theology of John Wesley, a theology of love and hope, was good news for hurting people who were suffering, bearing burdens of wrenching sin, who knew the slavery of self-will, for those who were lonely and tired, forsaken by an indifferent society. Wesley's theology offered succor in place of neglect, hope in place of despair, and love where none existed. This theology of holy love places Jesus Christ at the very center of salvation history. Jesus's counsel and ministry considers his two natures, divine and human, that teaches believers how to live. Wesley's theology is deeply rooted in Christology which consists of the seriousness of sin and human need,

inclusive of God's grace and provision (Collins 96, 329-30). People found solace in the Jesus whom John Wesley preached.

In Wesley's 1741 sermon, "The Almost Christian," based on Acts 26:28, he preached that believers need to become *altogether a Christian,* and not *almost a Christian*. His text allowed him to preach to a difficult audience, calling them to repentance of living outside of a real Christian and the ministry of Jesus. Wesley preached that the first thing in being an altogether Christian, is that a believer must have the love of God engross the whole heart. He supported his sermon by quoting Scripture: "Thou shalt love the Lord thy God with all thy heart and with all thy soul, and with all thy mind, and with all thy strength." With such a love as this, Wesley said a believer is dead to pride because love is not puffed up. The believer becomes crucified to the desires of the eye and flesh, and the pride of life. The love of our neighbor is the second thing in being an altogether Christian (Collins and Vickers 66-69).

Wesley quoted Scripture: "Thou shalt love thy neighbor as thyself." He concluded his sermon by proclaiming that the third and final thing to becoming an altogether Christian is faith; a faith that purifies the heart and desires nothing but God. Whoever has this faith is what Wesley refers to as *working by love*, and the believer is not an almost Christian, but an altogether Christian (Collins and Vickers 66-69). Wesley concluded his sermon by telling his listeners, "May we all thus experience what it is to be not almost only, but altogether Christians! Being justified freely by his grace, through the redemption that is in Jesus, knowing we have peace with God through Jesus Christ, rejoicing in hope of the glory of God, and having the love of God shed abroad in our hearts by the Holy Ghost given unto us!" (69).

John Wesley's 1786 sermon, "On Visiting the Sick," was based on Matthew 25:36: "I was sick, and ye visited me." Wesley preached, "By the sick, I do not mean only those that keep their bed, or that are sick in the strictest sense. Rather I would include all such as are in a state of affliction, whether of mind or body; and that whether they are good or bad, whether they fear God or not" (Collins and Vickers 206). Sending a physician or someone else to visit the sick instead of yourself does not answer the call of Scripture. In answering the call, the believer must first turn to God for wisdom. Performing the visit yourself is the only way to fulfil your own duty of sympathy for the afflicted and social affections. Sending someone else in your place to visit the sick does not increase your benevolence. Wesley pointed out that the physician can do good for the person's physical body, but cannot do good for the person's soul. He said that the soul is of greater importance than the body (206).

Jurgen Moltmann's Theology of Hope

Jurgen Moltmann's theological theme of hope gives hopeless people reasons to not give up. "Hope is nothing else than the expectation of those things which faith has believed to have been truly promised by God" (20). Faith and hope build and feed on one another. Faith is the foundation that hope rests upon. By patient hope and expectation, faith is sustained and nourished. Only by unremitting renewal and restoration does hope invigorate faith with perseverance over and over and over again. Without hope, faith falls apart and eventually dies. Hope becomes a utopia that hangs in the air when it is without the knowledge of Christ through faith. It is actually faith in Christ that gives hope its assurance. Faith in Christ can sustain a hopeless, suicidal person to find a path of true life, but it is hope that can keep him on that path (Moltmann 20).

Moltmann brilliantly explained, “Just as the urge of promise is towards fulfilment, as the urge of faith is towards obedience and sight, and as the urge of hope is towards the life that is promised and finally attained, so is the urge of the raising of Christ is towards life in the Spirit and towards the eternal life that is the consummation of all things” (Moltmann 213). Where faith believes, hope anticipates. Moltmann said that the suffering in the prisoner of war camps during World War II gave birth to his theology of hope. From the suffering, people who emerged from the war with hope had learned to transform their experiences in making “meaning” of the realities they faced. Those meanings were their hope’s catalyst (Bock 16-17).

Theological Interpretations of Suicide and Hope

St. Augustine, in the fifth century, argued that suicide was a violation against the Mosaic Law’s sixth commandment: “Thou shalt not kill.” This violation applied to not only the lives of others, but one’s own life. He said that everyone’s life should be preserved. St. Thomas Aquinas, a Catholic theologian, added to Augustine’s perspective. St. Aquinas said that suicide is a sin against oneself, your neighbor, and God. He further explained that suicide is against nature and contrary to religious rights. St. Aquinas said that only God has the right to determine when a person lives or dies. He also believed that a person who completed suicide could not confess to the suicidal act and repent, therefore making suicide the most serious of all sins. The Christian perspective on suicide has been pretty much the same since the fifth century perspective (Gearing and Lizardi 334).

An interesting theological perspective for understanding suicide is that killing oneself is an omnipotent act. In ministering to a suicidal person, this theological

perspective should be given some thought. The power of creation is also within the suicidal person to make changes and a theologically oriented therapist could help bring the suicidal person to this awareness of the power of making changes. The power of self-destruction needs to be understood from a suicidal person's perspective in order to encourage and support love, hope, and healing to combat the suicidal behaviors (Close 18). Rev. Henry T. Close, Chaplain at Georgia Mental Health Institute discusses that killing oneself is an absolute act of self-will. When a person kills himself or herself, the person ends the relationship with his or her whole world. Therefore, ending your relationship with the world is an omnipotent act. Thus theologically, a person who kills oneself had taken on the entitlement of God to prove independence and a new freedom. Anger against the world is experienced as anger against oneself. The suicidal person feels that the only way to destroy the world is to destroy oneself (18).

Rev. J. Philip Wogaman, of Wesley Theological Seminary, argues that the Jonestown Mass Suicide offered an example of a problem that humanity faces daily. Each day humanity faces despair and a lack of hope in God so deep that it leads to suicide. Responding to the Jonestown Mass Suicide, Protestant Theologian Alan Davies says that nothing is worse than bad religion because Jonestown's suicides supposedly occurred in a religious context. Philosopher Paul Ricoeu believes that issues with evil have been forgotten by today's liberal theologians. He also fears that people who try to disconnect themselves from Jonestown will think that they are good people and it cannot happen to them ("Religion: Looking Evil in the Eye" 51).

Historical Protestantism and Suicide

The role of religion, confessing the sin of attempted suicide, and consideration of the afterlife are relevant considerations to suicidal behavior in determining how protected religious men and women were from committing suicide. Based on *Thou shalt not kill*, the sixth commandment, suicide was viewed as a sin and forbidden in Protestantism and Catholicism. In 1897, Emile Durkheim showed evidence that Protestants have higher suicide rates than Catholics, due to Protestantism having a leading correlate of suicide incidences. He argued that Protestantism encourages religious individualism and independent thought, decreasing the Protestants' participation as part of a unified religious community like Catholics. The cost of committing suicide is greater for someone in a faith tradition, like Catholicism. For Catholics it is less likely for them to break away from a community of strong cultural religious practices and beliefs. Suicide would have a huge negative effect on other people who are also strongly integrated in their Catholic religious community with more social support, resulting in less suicides (Becker and Woessmann 1-2, 5, 7).

Riaz Hassan supports Durkheim's argument that when a person is not integrated into society and has to rely on one's own resources, this results in excessive individualism. Statistical evidence supported Durkheim's claim that Protestants experienced higher suicide rates than Catholics (169). Durkheim asserted that since Protestants do not have a strong religious community tie, therefore they have higher suicide rates because of this individualism. Protestants believe in God and the immortality of the soul. On one hand, Protestant doctrine supports that Protestants cannot affect God's decisions by their deeds, but fully depend on God's grace to gain

access to heaven. On the other hand, Catholic doctrine supports that people's access to heaven is affected by their deeds, which lowers their threshold to commit suicide (Becker and Woessmann 24).

Current Protestantism and Suicide

Protestants have the highest suicide rates, followed by Catholics. Jews have the lowest rate of suicide among monotheistic religions. Research supports a relationship between high levels of religiosity with decreased risks of suicidality. People who attend church frequently are four times less likely to commit suicide than people who do not attend church. Most faith traditions have strong sanctions against suicide that are protective factors. It was Durkheim who first proposed that a spiritual commitment provided a source of meaning and order in the world that contributed to emotional well-being (Gearing and Lizardi 332-33).

How does the Protestant church view suicide in our society today? The Lifeway Research study supports the church's involvement, awareness, and education concerning suicide. However, suicide remains a taboo subject in many Protestant churches, despite the best efforts of pastors, according to a 2017 study from Lifeway Research. Eight in ten Protestant senior pastors believe that their church is equipped to intervene with someone who is threatening suicide. Yet, few people turn to the church for help before taking their own lives, according to their churchgoing friends and family. Only 4% of churchgoers who have lost a close friend or family member to suicide say church leaders were aware of their loved one's struggles. Scott McConnell, executive director of Lifeway Research, said that despite churches' best intentions, they do not always know how to help those facing mental health struggles. The Lifeway Research study surveyed

1,000 Protestant senior pastors and 1,000 Protestant and nondenominational churchgoers. They attended church services at least once a month. The study found three-quarters (76%) of churchgoers said suicide is a problem that needs to be addressed in their community and about a third (32%) said a close acquaintance or family member died by suicide (Smietana, "1 in 3 Protestant Churchgoers").

The Lifeway Research study, that focused on pastors' and churchgoers' views regarding suicide, showed that very few people at risk of suicide talked to their church communities about their personal struggles. The church could bridge a huge gap by taking advantage of the education offered that identifies the warning signs of suicide. The ability to acquire this valuable information would provide the church an opportunity to raise awareness to counter the rising trend of suicides and perhaps even save lives. Through preaching, sermons can be used to break the stigmas surrounding suicide (Smietana, "New Research"; Lifeway Research; Stetzer). Creel says that if believers turn toward the Kingdom of God, then believers turn toward treating others with dignity, turn toward healing them, and turn toward promoting others' well-being. We turn toward making others feel welcomed and valued, and not making strangers feel unwelcomed, inferior, or invisible (Creel 15).

Jesus said, "Love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength. You shall love your neighbor as yourself. There is no other commandment greater than these" (Mark 12:30-31). Ed Stetzer, in his CT Blog Forum, provided directives that churches need to be generous with their time and resources, even though it may not be convenient or easy. Churches could host training seminars to equip their congregants on how to identify and become friends to

people with mental illness. Church leaders do not need a Ph.D. in Clinical Psychology. Church leaders must be intentional about equipping their congregants to be good neighbors, acquire helpful outside resources, and promote congregational participation (Stetzer). Rachael A. Keefe explains that those in the field of suicidology have said that suicide is 100% preventable. Yet, we really should say that suicide could be dramatically reduced if people would stop denying and masking their suicidal ideations and intents. They do this due to so much stigma and shame around suicidality. If we work toward removing the stigma, then the prevention of suicide would become more preventable (77).

Suicide Information

In 2019's world of technology, information on suicide is more available to the pubic than it was decades before because of the internet. Computers, cell phones, tablets, and iPads are found in homes, schools, stores, workplaces, and libraries. A person does not have to purchase books to acquire information; a Google search on any electronic device will display data instantly. When the term "Suicide" was entered in the Bing search engine, the WebMD website came up as a leading choice in a number of resources on suicide. The website's discussion on suicide was entitled "Suicide Warning Signs: What to Watch for and Do." Valuable information on the warning signs of suicide, and statistical data from numerous sources about suicide were displayed all in one place. A medical doctor's name and the last review date was displayed. The first hit on the term "suicide and warning signs" in an internet search was a medical resource full of vital information to save lives. The National Suicide Prevention Lifeline number, 1-800-273-8255 (TALK) was highlighted, on the website, and assured that the line was always open

with a trained counselor available to talk with anyone thinking about suicide. Another tool developed for crisis support is a cell phone texting system. One can text "Connect" to 741741 to seek a free, 24/7, confidential, and nationwide counselor (*Crisis Text Line*).

Suicide Statistics in Kentucky

The following suicide statistics from the most current sources prove the rising trend of suicides among adults nationally and statewide in Kentucky. Suicide rates published by the Centers for Disease Control and Prevention (CDC) in June 2018, supported that suicide rates in the United States continue to increase. "Suicide is one of the top causes of death in the U.S., with rates rising across the country. Nearly 45,000 Americans died by suicide in 2016, according to the CDC" ("Suicide Warning Signs"). In 2016, suicide ranked as the tenth leading cause of death in the United States (Kochanek et al, 2017).

Based on statistics for 2012-2017 Suicidal Deaths for Adults (18-65+), as the country's population increased, Suicide Deaths also rose, both as absolute numbers and as the Crude Rate per 100,000.

Table 2.1

2017 – 2012, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 18 to 85+
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population	Crude Rate
2017: 45,390	252,063,800	18.01
2016: 43,427	249,747,123	17.39
2015: 42,790	247,411,463	17.30
2014: 41,478	245,051,479	16.93
2013: 39,894	242,660,171	16.44

Number of Deaths	Population	Crude Rate
2012: 39,426	240,292,912	16.41

("Fatal Injury Data").

At least three experts concur that suicide is on the rise in the United States. Kathleen Doheny examined and discussed CDC data on suicide rates. She agreed that suicide is on the rise across the United States, claiming that nearly 45,000 Americans age 10 or older in 2016 died, and is the 10th leading cause of death in this country. Suicide, Alzheimer's, and drug overdoses are the only ones increasing according to CDC officials. Middle-age adults are among the hardest hit by suicide. Doheny's article agreed that suicide is preventable, and that action is needed to be taken according to Anne Schuchat, MD, principal deputy director of the CDC. Schuchat said that suicide is preventable and the CDC has a goal of lowering it by 20% by 2025, if only the states and communities could come up with comprehensive programs (Doheny).

According to Mark S. Kaplan, a professor of social welfare at the UCLA Luskin School of Public Affairs, the actual statistics about suicide may be higher because many suicides have been classified as accidental deaths. Therefore, they are classified as unintentional self-injury when in fact, a closer look reveals they look more like suicides; the true number of suicides is not known (Doheny). The caveats and limitations in capturing accurate suicidal data are that suicide is not a recorded cause of death for persons less than five years old. The data might also be undercounted by the coroner or medical examiner in the difficulty of determining suicidal intent. With this insight, the suicidal deaths and rising trends may be worse than the statistics that have been recorded. ("Reduce the Suicide Rate").

Although the Healthy People 2020 target was to reduce suicide rates to 10.2 per 100,000 by 2020 ("Mental Health and Mental Disorders"), suicide rates have steadily increased in recent years. "The 2015 suicide rate (13.3) was 28% higher than in 2000" (Curtin et al. 285). This Data Brief uses the most recent data from the National Vital Statistics System (NVSS) to update trends in suicide mortality from 2000 through 2016" (Hedegaard et al., "Suicide Rates"). The Centers for Disease Control and Prevention (CDC)'s Data Briefs 309 and 330 are in agreement on their suicide data. According to Lea Winerman, there has been an alarming rise in suicides in the United States over the past two decades. She agreed with and repeated the statistical data discussed in CDC's Data Brief 309 (80).

Additionally, data published by the National Center for Health Statistics (NCHS) also reported a rising trend of suicides in the United States from 1999 through 2017. "This report highlights trends in suicide rates from 1999 through 2017. During this period, the age-adjusted suicide rate increased 33% from 10.5 per 100,000 in 1999 to 14.0 in 2017" (Hedegaard et al., "Suicide Mortality"). The American Foundation for Suicide Prevention reported that suicide is the 10th leading cause of death in the US. In 2017, 47,173 Americans died by suicide, in addition to an estimated 1,300,000 suicide attempts ("Suicide Statistics").

Regarding data examined and acquired statewide for Kentucky, the American Foundation for Suicide Prevention's 2018 facts and figures reported that on average one person dies by suicide every 12 hours in the state of Kentucky. Kentucky placed number 20 in a suicide ranking of all states in the United States of America. Suicide is the 11th cause of death in Kentucky. The suicide rate of 16.79 per 100,000 population translates to

756 deaths by suicide. Nationally, the number of deaths by suicide is 44,695 ("Suicide Facts & Figures: 2018"). More specifically, the Kentucky Cabinet for Health and Family Services/Department for Behavioral Health, Developmental, and Intellectual Disabilities (BH/DID) reported that in the past decade, an average of 669 Kentucky citizens died by suicide annually. More than three times as many people die by suicide annually in Kentucky than die by homicide. Kentucky's suicide death rate is the sixteenth highest in the nation. Various sources agree that suicide is the eleventh leading cause of death overall in Kentucky. Suicide is the second leading cause of death for ages 10–34, and the fourth leading cause of death for ages 35–44. Suicide disproportionately affects Kentucky's senior citizens ("Suicide Prevention Program"). While Kentucky's rates and numbers have fluctuated up and down, after dropping in 2016 from a higher rate in the previous year, the rates since then have increased.

Table 2.2

2017 – 2012, Kentucky
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 18 to 85+
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population	Crude Rate
2017: 744	3,443,650	21.60
2016: 728	3,424,592	21.26
2015: 750	3,410,006	21.99
2014: 715	3,396,344	21.05
2013: 686	3,383,151	20.28
2012: 708	3,365,807	21.04

("Fatal Injury Data").

The rising trends in suicidal deaths, nationally and statewide, have also been found across the world (Jobes and Linehan xii). The World Health Organization (WHO) reported in August 2018 that close to 800,000 people die of suicide every year; this is one person every 40 seconds. Suicide occurred throughout the lifespan and was the second leading cause of death among 15 to 29-year-olds globally. Suicide is a global phenomenon (*WHO Releases Progress).* "79% of suicides occurred in low- and middle-income countries in 2016. Suicide accounted for 1.4% of all deaths worldwide, making it the 18th leading cause of death in 2016" (*WHO Releases Progress*).

Suicide Attempts Statistics

More people attempted suicide but did not die. An enormous number of suicidal attempts is as much a concern for the Unites States as suicidal deaths. The following are the CDC's national suicidal attempt statistics, that did not result in death.

Table 2.3

Self-harm All Injury Causes Nonfatal Injuries and Rates per 100,000
2017-2012, United States, All Races, Both Sexes, Ages 18 to 85+
Disposition: All Cases

	Number of injuries	Population	Crude Rate
2017:	394,352	252,063,800	156.45
2016:	397,975	249,747,123	159.35
2015:	405,731	247,411,463	163.99
2014:	375,530	245,051,479	153.25
2013:	405,300	242,660,171	167.02

Number of injuries	Population	Crude Rate
2012: 406,796	240,292,912	169.29

("Nonfatal Injury Data").

A study was conducted that estimated the rates of deaths by suicide among adults who attempted suicide in the United States. Focusing on demographic characteristics can help identify the population of suicide attempters who are at a higher risk for death by suicide. The study's results estimated the completed suicides based on the number of suicide attempters. The strongest predictor of completed suicides is suicide attempt history. The suicide attempters at higher risks can be prevented from becoming completed suicides by providing them increased access to suicide prevention, intervention efforts, and mental health treatment (Han et al. 125). "Over 1.3 million adults ages 18 or older in the U.S. reported in 2012 that they attempted suicide in the past 12 months. Among adult suicide attempters in the U.S., the overall 12-month suicide case fatality rate was 3.2%. Current suicide prevention and intervention efforts may be enhanced by focusing on identified high-risk suicide attempters, especially those non-Hispanic white men aged 45 or older who did not complete high school education" (Han et al. 125, 130).

A suicidal patient may require protective controls against suicide intents. Acute hospitalization would help a person become stable on a treatment plan. Tendencies to become isolated and uninvolved indicates the value of being part of group-oriented therapy. A group environment supports and encourages the development of social attachments for an isolated person. Behaviorally focused and cognitive change therapies prove helpful for the suicidal patient (Firestone and Catlett 690).

Another study showed that people denied their suicidal intent concerning a self-inflicted gunshot wound when taken to a trauma center. The study's evidence suggested that suicide attempts by self-inflicted gunshot wound (GSW) were underreported and may have affected the patient's disposition following hospitalization. This study aimed to evaluate the individuals who did not disclose suicidal intent following a self-inflicted GSW. One hundred twenty-eight survivors, of self-inflicted GSWs at a level 1 trauma center, were analyzed to identify factors associated with nondisclosures of a suicide attempt to medical staff. Twenty-nine percent of the patients denied that a self-inflicted GSW was a suicide attempt. Forty-three percent of the patients who denied suicidal intent were identified by the psychiatric consultation and liaison service as being suspicious of a suicide attempt by GSW (McClay et al. 1). Gunshot-wounded patients who denied a suicide attempt were nearly eleven times more likely to be discharged to their homes, although they may have been better treated if transferred to inpatient care in the hospital. Suicide attempt survivors do not give honest reports for fear of hospitalization (7).

Ten psychologists conducted an empirical and quantitative study and determined that, unfortunately, even mental health providers are not immune from faulty beliefs about suicide. For example, concerns over the potentially stigmatizing and discouraging effects of diagnostic labels motivate many clinicians to withhold diagnostic information from their clients who report suicidal ideation. A clinical effectiveness study of fifty-three adult outpatients at a community-based clinic was conducted to better understand how patients are emotionally affected when they receive diagnostic feedback (Holm-Denoma et al. 555). "Results indicated that clients reported no change in negative

emotions (such as shame and fear) and significant increases in positive emotions (such as hope and validation) following diagnostic feedback provision. These results suggest that diagnostic feedback, when provided in a careful and constructive manner, tends to increase clients' positive emotions and potentially their hope for treatment" (Holm-Denoma et al. 555). Therefore, clinician disclosure of testing and diagnostic information is considered a better practice for suicide intervention than withholding such information from clients. The clinical study did not support that diagnostic feedback led to an increase in clients' negative emotions (Rudd et al., "Realities of Risk" 475; Holm-Denoma et al. 572).

Warning Signs and Causes of Suicide

The warning signs to look out for from a clinical point of view are that an individual focuses on death, or makes plans by giving away stuff and saying goodbyes, become withdrawn from close friends and family, shows despair feeling like he/she is a burden, shows swings in mood or sleep, drinks or takes drugs, and/or acts recklessly in taking dangerous chances like driving drunk or having risky sex. People at risk of suicide may have mental disorders, addictions to alcohol or drugs, serious physical illness, major loss of a loved one through death or ended relationship, serious legal or financial problems, or a history of trauma or abuse. All warning signals should be taken seriously. It is important to understand that talking about suicide will not make the person act on their feelings ("Suicide Warning Signs").

The American Foundation for Suicide Prevention states important conditions that might cause a person's risk of suicide to increase:

> while there is no one single cause for suicide, depression is the most common condition associated with it. Moreover, depression can often go undiagnosed or untreated. Conditions like depression, anxiety and substance problems, especially when unaddressed, increase a person's risk. ("Suicide in Kentucky/Facts and Prevention")

Knowledge and awareness of these conditions could lead to interventions to help decrease the person's risk of suicide.

Suicide is preventable if interventions can be created and utilized in our communities. Knowing these suicide risk factors and warning signs are essential to saving lives. When concerned that a person may be suicidal, look for changes in behavior or new behaviors that seem out of character. This change is of most concern if the new or changed behavior is related to one of the risk factors and one or more warning signs.

Table 2.4

Suicidal Risk Factors and Warning Signs

Mental Health Disorders: Depression, Bi-polar, Anxiety, Alcohol and Drug Abuse
Mood Displays: Rage, Irritability, Humiliation
Serious or chronic health condition and/or pain
Losses: Death, Divorce, Job Termination, Sleep, Relationship
Harassment or Bullying
Historical Factors: Previous suicide attempts, Family history of suicide attempts
Talk of: Being a burden, feeling trapped, no reason to live, killing themselves
Isolation from: Family, Friends, Activities
Saying "Goodbye" and giving away prized possessions

("Suicide in Kentucky/Facts and Prevention")

Suicide Preventions and Interventions

Prevention and intervention begin with knowing what to look for as warning signs and what to do when the warning signs are encountered in a suicidal victim. Multiple organizations and initiatives advance suicide prevention programs or propose elements of

successful suicide prevention including identification of persons at high risk of suicide, community-based services which foster support and reduce patient/client isolation, and training for professionals who may have contact with suicidal persons.

The National Action Alliance for Suicide Prevention is the public-private partnership that is working to reduce the suicide rate twenty percent by 2025. They are doing similar work as Healthy People 2020. Action Alliance also works to advance the National Strategy for Suicide Prevention. They have found gaps in the care for people at risk of suicide and said that these gaps need to be closed. They said that if the tide of suicide deaths is to be turned, then change is needed now; so that people at risk of suicide can be identified, supported, and kept safe. Suicide is preventable. If someone is threatening to kill themselves, most importantly, never leave them alone. In most cases, people who commit suicide do not want to die, but they want to end their pain ("Suicide Warning Signs").

The community is a key setting for suicide prevention programs. Community-based programs support the development of life skills and positive social connections, help to identify suicidal persons, ensure available crisis services, develop linkages for continuous care of people at risk of suicide, reduce access to lethal means for those in suicidal crisis, and provide support for family and friends bereaved by suicide. According to Action Alliance, the seven key elements of community-based suicide programs are: Unity (Momentum around a shared vision), Planning (Roles and outcomes), Integration (Use of multiple prevention strategies), Fit (Alignment of activities with context, culture, and readiness), Communication (Clear, open, consistent),

Data (Guide action, assess progress, make changes), and Sustainability (Focus on long-lasting change) (*Transforming Communities*).

For community-based suicide prevention programs to be successful and to avoid isolation of the person at risk of suicide, Hogan and Goldstein Grumet propose that people at risk of suicide receive excellent support during inpatient or emergency department care transitions to home care to avoid isolation. "Isolation is a strong risk factor for suicide. Therefore, successful care transitions are especially important for suicidal patients. Additionally, timely supportive contacts (calls, texts, letters, and visits) should be standard after acute care visits or when services are interrupted" (Hogan and Goldstein Grumet 1088). Hogan and Goldstein Grumet advocated for the development of support venues to help discharged persons, who struggled with suicidal ideations or attempts, transition to life outside of these more restrictive care facilities. David Luxton, Jennifer June, and Katherine Comtois also agreed that the risk of another suicide attempt or death is greater within a month's post discharge from inpatient or emergency department care. Luxton, June, and Comtois added that up to 70% of suicidal persons who leave emergency services fail to attend their follow-up appointments. The evidence reported that follow-up venues might reduce suicide risk (Luxton et al. 32; Hogan and Goldstein Grumet 1088-89).

Training in Suicide Assessment

The National Action Alliance for Suicide Prevention started the Clinical Workforce Preparedness Task Force in 2010. The Task Force was established to promote progress in the clinical workforces' competencies that serve people at risk of suicide. A core set of training guidelines using a three-step process was developed. The Task Force

discovered through their research of literature reviews and surveys of licensing entities, accreditation entities, and educational institutions that there were very little suicide assessment requirements and intervention training. The Task Force findings support the arguments for the need for more suicidal awareness, education, training, and support in suicide prevention. The Task Force defined the target population of the training they developed as individuals who engaged in direct service to people at risk of suicide, professionals such as nurses, social workers, physicians, and psychologists. Excluded in their scope were first responders and other, often critical, workforces that included community and faith-based resources; clergy, and community crisis lines' staff (*Suicide Prevention and the Clinical Workforce*).

Expert perspectives on No-Suicide Contracts have changed with an alternative proposal. The problem with the term *contract* identified hidden messages embedded in the word itself. A contract may limit open and honest dialogue with patients because they have nothing to gain by signing it. This genre of language may result in the added burden of appearing to free the clinician from blame for any bad outcome the patient has in treatment. Rudd and his colleagues agreed that the term *contract* should be removed, and an alternative term supplied (Rudd et al., "Case Against No-Suicide" 244-45). "Kroll (2000) found that 41% of clinicians who used no-suicide contracts had patients who died by suicide or made very serious attempts while under contract. Kelly and Knudson (2000, p.1120) reached a similar conclusion to that suggested here, stating that no empirical evidence supports the effectiveness of no-harm contracts in preventing suicide" (Rudd et al., "Case Against No-Suicide" 246).

As a result of the previous findings, a practical alternative that Rudd, Mandrusiak, and Joiner recommended was the use of a Commitment to Treatment Statement (CTS). "It is defined as an agreement between the patient and clinician in which the patient agrees to make a commitment to the treatment process and living by (1) identifying the roles, obligations, and expectations of both the clinician and the patient in treatment; (2) communicating openly and honestly about all aspects of treatment including suicide; and (3) accessing identified emergency services during periods of crisis that might threaten the patient's ability to honor the agreement" (Rudd et al., "Case Against No-Suicide" 247). The authors believed that it is critical that the effectiveness of these agreements should be early in the patient's treatment process. This instrument focuses on the positive, the patient's treatment and emergency help in time of crisis, instead of focusing on contractually not committing suicide. This can be simple and should be handwritten. The family member or spouse can be included as a witness to the CTS agreement. Therefore, completing the CTS agreement is a strategy. The Crisis Response Plan (CRP) encompasses information about the patient, concerned persons in the patient's life, and the clinician, creating a positive support for the person who struggles with the risk of suicide (248). The CRP creates protective factors and targets emotional regulations, self-management, and crisis response skills. No-suicide contracts are discouraged. Follow up with suicidal patients is vital to monitor any changes in suicidal risk levels (Bryan et al. 152).

It is important that definitions of suicidal terms be consistent and not create confusion when discussions are held between clinicians, patients, family members, and the community. M. David Rudd defined suicidal terms for clinical consistency. He said,

"Directly related to improving the quality of clinical care provided suicidal patients. First, it is essential to emphasize the importance of language in clinical practice. Precise definitions need to be used; this includes how we talk to patients, how we talk to one another, and how we document our assessment and management decisions" (6). Agreements on suicidal terminology could assist to eliminate any confusion or misunderstanding of a suicidal patient's diagnosis.

Furthermore, a clinical and sound suicide assessment approach or protocol must be practiced for each patient. Used in uncovering suicidal intent, Shawn Christopher Shea, MD, called suicide assessment, *a sophisticated art*. A sound approach is made up of three components: (1) Collecting information related to risk factors, protective factors, and warning signs of suicide; (2) Collecting information related to the patient's suicidal ideation, planning, behaviors, desire, and intent; and (3) Making a clinical formulation of risk based on the two databases derived from data from #1 and #2. Innovative systematic approaches, such as the Collaborative Assessment and Management of Suicidality (CAMS) approach created by David Jobes, were developed for integrating all 3 tasks while providing collaborative interventions. This development helps to lay the foundation for a more evidence-based protocol for suicide assessment (Shea, "Assessment Part 1" 1).

"For positive screenings, the BHC (Behavioral Health Consultant) should access the nature and content of the ideation to clarify whether the patient is experiencing suicidal ideation or nonsuicidal morbid ideation" (Bryan et al. 149). Knowing the difference between the two ideations is important. Nonsuicidal morbid ideations include thoughts or wishing death with no intentions of harming oneself. Rudd, Cukrowicz, and

Bryan further explained, “The core competencies in suicide risk assessment and management cover seven primary clinical skill set domains: attitudes and approach, understanding suicide, collecting accurate assessment information, formulating risk, developing a treatment and services plan, managing care (i.e., immediate response to identified risk level), and understanding legal and regulatory issues related to suicidality” (Rudd et al., “Core Competencies” 220).

Despite the huge humanitarian and economic toll of suicide, American mental health systems of care are largely underprepared to access and work effectively with suicidal individuals. In 2016, The Joint Commission declared that suicide was a leading “Sentinel Event” in United States health care settings. In response to these concerns, a policy initiative called “Zero Suicide” was advocated as a systems-level response to the suicidal risk within health care. A *stepped care* approach developed by Jobes has been adapted and used within the Zero Suicide curriculum as a model for a suicide-specific, evidence-based, least-restrictive, and cost-effective system-level care.

The Collaborative Assessment and Management of Suicidality (CAMS) became an evidence-based clinical intervention that was highly adaptable and used across stepped-care service settings for a range of suicidal patients. It has been argued that psychological services are uniquely poised to make a major difference in clinical suicide prevention through this systems-level approach using an evidence-based care like CAMS. CAMS effectively increased hope and retention to care. CAMS also reduced suicidal ideations and psychiatric distresses (Jobes et al., “A Stepped Care” 243, 247, 249; Jobes and Chalker 4). Jobes and his colleagues further reiterated that the state of affairs pertaining to the assessment and treatment of suicidal patients is both a professional and

an ethical crisis for those who practice in the challenging field of mental health. The Centers for Disease Control and Prevention reports that suicide death rates have risen over the past decade. These rising rates have impacted millions of lives and much more needs to be done to decrease suicide-related suffering to save lives (Jobes 207-08; Jobes et al., "Ethical and Competent" 406).

David Jobes' interview proposed CAMS as a possible remedy for effectively treating suicidal risk. He explained that the treatment plan is anchored by the CSP [CAMS Stabilization Plan]. This plan, developed between the clinician and the patient, focuses on the elimination/reduction of lethal means and the use of five coping strategies that can be used should the patient become acutely suicidal. Clear contact information is available of whom to contact in case these coping strategies fail to stop a prospective suicidal crisis. The CSP includes the names of key people who are supportive of the patient, along with their phone numbers to help decrease a patient's isolation. Possible remedies to potential barriers for the patient to attend treatment are noted as part of the plan, e.g., child care needs or transportation issues. Most importantly, the patient is advised to keep a copy of the CSP with them across the duration of care. One suggestion is to take a picture of the CSP with their smartphone. The main goal is to do everything possible to save a suicidal patient's life (Jobes 213; Rubin).

As previously discussed, clinical assessments are very important in identifying an individual's suicidal intent in reducing actual suicidal deaths and active suicidal attempts. CAMS was designed to empower clinicians by empowering their patients. "Merely understanding the nature of a patient's suicidal struggle may not be enough to clinically prevent suicide, but it is an excellent starting point for life-saving work. Beyond

understanding, there is a fundamental requirement to effectively *manage* suicidal risk, both clinically with the patient and within ourselves as providers of care. Suicide is simultaneously complex, contentious, mysterious, terrifying, compelling, seductive, and horrifying – across all cultures and around the world" (Jobes and Linehan xii).

The ongoing national and international tragedy of suicide has spurred substantial prevention efforts. Lack of effective screening and identification of persons at risk is an obstacle to effective prevention. An evidence-supported, low-burden solution is the Columbia-Suicide Severity Rating Scale (C-SSRS). C-SSRS is another assessment tool used by clinicians to determine suicidal risk. This screening tool was developed by multiple institutions for the prediction of suicide attempts, and is one of the foremost national priorities for prevention. It is field-use ready. Mental health training is not required to administer it, so it can be administered by Chaplains to first responders. This tool is available in one hundred and three languages and an electronic self-report (e-CSSRS) is available and widely used.

Dr. Jeffery Lieberman, president-elect of the American Psychiatric Association, praised the C-SSRS assessment tool as an enormous achievement in terms of public health care and prevention of loss of life. New York State Office of Mental Health Commissioner Michael Hogan said that C-SSRS is a proven method to assess suicide risk and is a huge step forward in saving lives, as a part of a national and international public health initiative for assessing suicidal risk and behavior. The Action Alliance sought a national strategy to enable better prediction of suicidal risk and more efficient allocation of limited healthcare resources. C-SSRS became a key component of their strategy for suicide prevention ("Columbia-Suicide Severity").

Dr. Shawn Christopher Shea is the director of TISA (Training Institute for Suicide Assessment and Clinical Suicide) and creator of the internationally acclaimed Chronological Assessment of Suicide Events (CASE Approach). The TISA website provides the introduction, information, and trainings for the flexible interview strategy (CASE Approach) for eliciting suicidal ideation from a person at risk of suicide (*Training Institute*). The CASE Approach was designed to minimize the essential missing pieces of the puzzle during risk formulation. The goal was to create a practical and reliable interviewing strategy that could be used to maximize the validity of the patient's stated and reflected intent while minimizing withheld intent. No matter how tired or overwhelmed the clinician might be or how hectic the clinical environment may have become, the ultimate goal is to assist the clinician in determining the patient's actual suicidal intent.

The CASE Approach also allows experienced clinicians to study how to elicit suicidal ideation and suggests new ways of doing it. Returning to the Equation of Suicidal Intent, the CASE Approach provides a platform for exploring suicidal ideation and behaviors that may maximize the likelihood that (1) a patient will share what would have been withheld intent, (2) a patient will more openly share his reflected intent, and (3) the patient's stated intent will be as accurate as possible. The CASE Approach will hopefully play a major role in the training of psychiatric residents and other mental health graduate students in social work, counseling, and psychology, for whom sound suicide assessment skills are one of the most pressing educational tools sought (Shea and Barney e1-e29; Shea et al. 283-314; Shea, "Assessment Part 2" 24).

Voice therapy is a procedure practiced that gives language or spoken words to the negative thought processes at the core of a patient's self-destructive behavior. The purpose of this therapy is to separate and reveal elements of a person's "anti-self" system that originated in the internalization of any damaging childhood experiences and traumatic negative parental attitudes. Voice therapy enables the patient to verbalize any negative behaviors to change his or her core beliefs. It allows individuals a way to identify the early experiences that impacted them. A goal in psychotherapy is to help patients come to terms with the frustration and painful feelings that caused them to retreat to inward, self-nurturing patterns and self-destructive machinations (Firestone and Catlett 682, 688).

Kentucky Suicide Prevention Group discusses QPR on its website. QPR stands for question, persuade, and refer. It is an educational program that teaches ordinary citizens how to recognize a mental health emergency and how to get a person at risk the help they need. Gatekeepers become trained through QPR Suicide Prevention Gatekeeper Training. This training can take as little as 90 minutes. A Gatekeeper trained in QPR can recognize the warning signs of suicide, identify risk factors associated with suicide and attempts, know how to offer hope, ask the question, and know how to get help (Kentucky Suicide Prevention Group). "These warning signs are often given during the weeks preceding an attempt. QPR is designed to interrupt this terrible journey. Fact: People who talk about or threaten suicide often do go on to attempt or complete suicide. To prevent suicide, we must overcome this dangerous form of denial, apply QPR and, perhaps, save a life"

(Quinnett, *Question* 9-10). *Question* a person about suicide, *Persuade* the person to get help, and *Refer* the person to the appropriate resource (3).

Regarding Suicide Prevention Training, Wendi Cross et al. regard telephone crisis services as a critical part of suicide prevention in the United State and world-wide. Crisis counselors, and other community-based gatekeepers, must be trained to assess and intervene with suicidal at-risk individuals. Training large numbers of people in a standardized approach could pose immense logistic and resource challenges. Train-the-trainer models (TTT) are considered to be highly efficient in educating a large number of people. The master trainers teach the suicide prevention program to others who then conduct their own training to target audiences. The target audiences then carry out the target behaviors of the suicide prevention program. Suicide is preventable (202, 207).

Impact of Suicide on Family and Friends

Suicide alters the pre-existing relationships between family members and friends of a loved one who completed suicide. Talking about the suicide to confidants outside of the nucleus of family and friends, provided more freedom and safety when speaking their truths about the suicide. Careless and insensitive comments can cause severed relationships among the survivors. A suicidal death of a loved one is a traumatic bereavement. The trauma destroys previous assumptions that people held about the stability and predictability of their lives prior to the horrific loss. The trauma of a death by suicide affects the stability of the suicide survivors and realigns their immediate and social relationships as they seek to find meaning after their tragic loss (Barlow and Coleman 195-98).

Morgan Lee discussed the truth about suicide and how the loss of a loved one to suicide affects the griever. Anguish, pain, or survivor's guilt are among a number of emotions the griever feels. The griever often feels at fault and unable to stop the person. Questions and concerns cast doubts, helplessness, and shame on the family and friends of the deceased loved one. Confliction is felt because if it had been a murder, rage would be against the murderer. Yet, when the murder is the suicide of a loved one, grief and rage are against him at the same time. The griever is left conflicted and exhausted. People not articulating their suicidal ideations are often torn between the desire to die and the desire to live. Lee argues, "When the desire to die outweighs the desire to live or exceeds their capacity for coping mechanisms to handle their pain, that's when suicide takes place" (50).

When mentioning Karen Mason's book, *Preventing Suicide,* Lee agrees with Mason that people who are thinking about suicide want to be rescued and not die. Mason said that men die from suicide almost four times more than women because men use firearms. Yet, more women attempt suicides five times more than men. When a woman overdoses on pills to commit suicide, she allows a larger window for rescue and a desire to live than a man who uses a firearm to commit suicide (Mason 29-32; Lee). The education of people in close proximity to the person at risk of suicide is of prime importance. In addition to pastors and church members, which this project has targeted to educate, a clear understanding and knowledge of suicide risk factors and warning signs for family members and friends are vital in bringing an awareness of the rising trend of adult suicide.

Family members or spouses can be included as a witness to the patient's Commitment to Treatment Statement (CTS) agreement. Completing the CTS is a strategy that includes a Crisis Response Plan (CRP) naming the patient, including any concerned persons in the patient's life, and the clinician, thereby creating a positive support group for the person who struggles with the risk of suicide. This agreement is an important intervention tool created by patients in advance before finding themselves in trouble and in danger of wanting to terminate their lives. Active involvement of a significant other or family member in the ongoing treatment and management of high-risk patients. The CTS's witness signature includes a way for an important person in the patient's life to be involved in the patient's CRP (Rudd et al., "Case Against No-Suicide" 248).

Survivors of Suicide (SOS) support groups meet throughout the state of Kentucky for survivors who have lost parents and loved ones to suicide. SOS maintains a website that has a 14-day trial and then a monthly fee for survivors. The SOS website has a link on the Kentucky Cabinet for Health and Family Services website supporting it. Five churches in Kentucky hold SOS meetings at their buildings, while the other six listed meetings are held in a library, community care, and hospice centers. Persons dealing with grief and loss of life are the targeted population of these free-of-charge SOS support groups. No group meetings were listed or found anywhere in Kentucky for people who are actually at risk of suicide, for the prevention of suicide. ("Survivor of Suicide"; "Suicide Prevention Consortium").

Impact of Suicide on Clergy and the Church

Loren Townsend acknowledges that "pastors are frequent 'first responders' to suicide; pastors are often the first called to support a family in a suicide emergency.

Suicidal thoughts are often expressed first to pastors or other religious leaders who have caring, listening relationships with parishioners. Pastors are frequently called to care for individuals or family members after a spouse, parent, or child has unsuccessfully attempted suicide" (11). Townsend provides guidelines for managing parishioners with suicidal thoughts and intent. He states that it can be complex and time-consuming for clergy.

- Spend time learning about community resources before a crisis;
- Pastors should be prepared to spend intense, concentrated time managing a suicide crisis;
- Always take symptoms of depression, hopelessness, and any reference to death seriously;
- Always ask about suicidal thoughts. Remember – asking about suicide does not suggest suicide to people;
- Never, under any circumstances, try to intervene with a suicidal person who has access to a weapon or may become violent;
- Assume that every suicidal crisis, from low risk to high risk, will require ongoing pastoral care for persons involved;
- Use the Decision Tree to assist in pastoral decision-making (Townsend 51-52).

Positive spiritual support or negative religious support relies on the individual's perspective and the relationship the person has with God, the pastor, and the members of the church. When a person in crisis feels free and comfortable to ask for pastoral or congregational support, then it may be a positive religious experience. For some people, religious resources can be a negative factor for them when coping with stress. The individual may have a poor or troubled relationship with the pastor or congregation. A person in crisis might view their crises interpreted by the pastor or congregation as God's punishment. This religious intervention could be a deep, psychological, and stressful experience (92-93).

A suicide crisis can threaten loving images of God for someone who loses a loved one to suicide. Faith leaders may find a grieving person's fundamental faith in God shattered because his or her belief system insisted that all events are under God's control or all things work for the glory of God. De-escalation for individuals who lost both a loved one and their concept of God to suicide will be difficult to resolve and require intensive pastoral care from the pastor and congregation of the church. Townsend suggests that pastors can embody the presence of Christ in ministering by listening, imagining changing places with the parishioner, empathizing, and connecting. Recovery becomes the focus of ongoing pastoral care for the individual or family once the immediate suicide crisis has been managed (Townsend 111-13, 119).

Clergy consists of pastors and church leaders in the local church. Information from the Lifeway Research surveys supported the need for more active involvement from the church's congregants and leaders to help persons struggling with suicidal risk behaviors. Janet Meehan and colleagues concluded, from their survey, that the prevention of suicide after discharge requires early community follow-up and closer supervision of high-risk patients to stop the large number of completed suicides within three months of discharge (Meehan et al 129).

Ed Stetzer, in his Christianity Today Blog Forum, said, "Churches are much more likely to respond after a suicide has already occurred. 55% of churchgoers agree people are more likely to gossip about a suicide than reach out to the family in support" (Stetzer). Alan Hsu said, "Suicide rates are increasing. The trends are all heading in the wrong direction for almost every demographic. But if there is a silver lining, it is that the church is now more aware of mental health issues than it was 15 years ago" (Lee). Karen

Mason, Monica Geist, and Mollie Clark addressed in a study that clergy have a key role in suicide prevention but report that being undertrained may affect their ability to engage in a preventive role in caring for persons at risk of suicide. These authors performed a qualitative study with nineteen Protestant clergy. The clergy were interviewed to identify critical elements needed for competency-based suicide prevention training for clergy. The study reported that clergy engaged broadly with the issue of suicide with suicidal people, grieving families, and community members. The study also found a lack of standards for clergy suicide prevention training and, therefore, saw a need for ongoing education for clergy beyond initial academic programs (Mason et al., "Developmental Model of Clergy" 347, 357).

A later study conducted by Karen Mason, Esther Kim, and W. Blake Martin examined four hundred ninety-eight United States Catholic, Jewish, and Protestant clergy and their use of fifteen suicide prevention competencies. On average, 2.02 suicidal people request help annually from the clergy. About 29% do not have any suicidal people requesting their help annually. On average, 2.26 suicide deaths happened during their clergy role. Formal training with suicidal people averaged a total of 10.72 hours with no significant difference found between the three faith traditions. Without suicide-specific training, clergy were found to rely on their general pastoral competencies. The suicide prevention competencies were utilized more whenever clergy encountered more opportunities to care for suicidal individuals, developing the competencies as *on the job* training. Formal education did not prepare clergy to engage with people at risk of suicide (Mason, "Clergy Use of Suicide" 404-17).

This study suggested that although clergy often use suicide-related competencies, they also suggested the need for suicide-specific training. Clergy may not receive this training in their formal education and may need to seek continuing education in this area. Continued education is important to offer clergy consultation or coaching with experienced clergy or with mental health professionals, as they begin to engage with the issue of suicide in their ministry. This training will help to improve their use of competencies (Mason, "Clergy Use of Suicide" 418).

Due to negative attitudes some people received from their churches, within two years of a suicide attempt, at least 80 percent of survivors either leave the church they were attending, join another church, or stop attending church altogether. Disappointment due to unmet expectations, criticism, or judgmental attitudes and treatment are the most common reasons for suicidal people leaving the church (Mason 17; Biebel and Foster 169).

In spite of this, Mason argues that pastors, chaplains, and pastoral counselors should teach people to choose life, guide how to build lives worth living, and teach how to manage suffering. To prevent suicide, Mason states that church leaders can help their congregations by teaching life and death theology, moral objections to suicide, theodicy, and how to understand and manage suffering. Church leaders can teach about the issues of suicide and remaining stigma-free whenever people become suicidal, attempt suicide, or die by suicide. Church leaders can teach how to build a life worth living with meaningful belongingness and purpose. They can offer community where relationship skills are learned and practiced; offer a place where those who need support can get it and partner with others in preventing suicide. Faith leaders are needed to provide spiritual

perspectives and interventions for people at risk of suicide and the victim's family and friends (Mason 18).

Pastors, chaplains, and pastoral counselors provide spiritual care to people at risk of suicide; other medical and therapeutic professionals do not typically provide spiritual support. Pastors, chaplains, and pastoral counselors can be the gatekeepers who can identify people at risk of suicide, and connect them to mental health professionals (Mason 100; Weaver and Koenig 495). Spiritual interventions of prayer, opportunities for belonging and meaningful service, and teachings of hope, suffering, and self-love are vital for people at risk of suicide. Pastoral care for a person at risk of suicide would provide an attempt to seriously support and engage in mental health services, while helping the survivor to reflect theologically on courage to build problem-solving skills. Family members need support as they are the unsung heroes in their suicide prevention work. The friends and family survivors of a suicide incident are not the only ones touched by the suicide. Where a suicide occurs, everyone in the faith community is a suicide survivor (Mason 106, 124, 155).

Karen Mason further discussed suicide prevention training for gatekeepers who are in position for people at risk to confide in and turn to for advice. She suggested QPR (Question, Persuade, Refer) and ASIST (Applied Suicide Intervention Skills Training) for faith leaders to learn. A gatekeeper's role is required to recognize suicidal warning signs and know how to seek help for people struggling with suicide. Having people trained in suicide prevention in our faith communities could save lives (Mason 169-70).

Clinical psychologist Chuck Hannaford, who served on the Southern Baptist Convention Executive Committee's Mental Health Advisory Group, told Baptist churches

and pastors to actively combat stress, anxiety, depression, burnout, and loneliness—factors that contribute to suicide. Hannaford's recommendations are especially for pastors and clergy. Church leaders are not exempt from suicides and becoming suicidal. His recommendations are as follows:

- Set personal boundaries to allow time for self-care and family.
- Eliminate unrealistic expectations for work and ministry.
- Avoid social isolation because all believers need outlets and support.
- Note any family history of mental illness. A person with family history of mental illness is seven times more likely to experience a mental health issue, especially when under chronic stress. (Roach)

Understanding the Suicidal Mindset

What goes on in the mind of a suicidal person? Thomas Joiner determined that the theory of suicide is defined by thwarted belongingness and perceived burdensomeness as proximate causes for suicidal desire. The higher the measurements of these two related constructs, the greater the desire to commit suicide. Thwarted belongingness is measured by the "need to belong" that is either met or unmet. Thwarted belongingness makes the person feel disconnected, isolated from the group, alone and not fitting in. Perceived burdensomeness, is a mental state that others would be better off if the person was gone. Joiner explained that people perceive themselves as a burden to others, and perceive that death is the solution to a problem that is permanent and stable. Perceived burdensomeness makes subjects feel that they are an emotional or financial burden to everyone around them. To prevent suicidal deaths, Joiner and his colleagues developed a crisis intervention which targets elevated thwarted belongingness and perceived burdensomeness. This intervention is an Interpersonal Needs Questionnaire (INQ) developed to reliably measure thwarted belongingness (if their need to belong is met or not) and perceived burdensomeness (if they perceive that they are a burden on others in

their lives) It is a relevant measure of suicidal behaviors in addition to other risk assessment protocols (Joiner 98, 135; Van Orden et al. 198, 213; Lester and Gunn 221-22).

Although clinical experts give their opinions and measurements from their experiences with suicidal patients, the voices of people struggling with suicide intent can provide a different type of understanding as to what goes on in their minds. Seeking their thoughts can lead to hearing the voice and glimpsing what is in the minds of suicidal people. Specific personality traits and behavior patterns play a central role in suicidal individuals. Some people at risk of suicide consider suicide a human right and believe no one should interfere with their decisions to consider suicide. This type of thinking reveals the behavior that people are divided within themselves: One part of the person wants to live and be goal-directed and life-affirming. The other part of the person is self-critical, self-hating, and ultimately self-destructive. This ambivalence is always a factor when it comes to suicide.

Suicide may become the outcome of an individual's self-destructive behavior that is dominated by inwardness. Characteristics of an inward person seeks isolation and prefers gratification in fantasy while rejecting the real world. The person portrays a pattern of withholding positive behaviors and a decrease of personal feelings, positive qualities, and talents. An inward person has prevalent feelings of self-hatred and cynical attitudes toward others, including the use of addictive substances and compulsive routines resulting in a lack of direction in life. These traits have behavior patterns that correspond as many precursors of suicide. Self-destructive behaviors can be found on a continuum from self-denial, to substance abuse, and then to actual suicide (Firestone and Catlett

682-83, 688-89). Regarding the suicidal mindset, Rev. Henry T. Close explains, "Suicide is a way of emotionally killing the enemy. The suicidal person wants to kill off a part of himself so the rest of him can come alive. But he feels that the only way to kill a part of him is to kill his whole person" (19).

Voice Therapy is used to help individuals identify destructive thoughts, attitudes, and beliefs. Voice Therapy exposes the split that exists in each person between the real self and the anti-self (Firestone et.al., *Self Under Siege* 2). In his Separation Theory project, Robert Firestone identifies and explains the split within a person as between the *real self* and the *anti-self*. The real self represents the life-affirming side of the personality, while the anti-self represents the self-destructive elements of the personality. The critical inner voice is a negative thought process conceptualized as the language of the anti-self, referred to as the *voice*. These negative thoughts of self-attacks exist on a continuum, from mild self-criticism, to extreme self-hatred, and to an authoritative directive to commit suicide (Firestone 439-40).

Self-destructive behaviors can also be found on a continuum from self-denial, to substance abuse, and then to actual suicide. Suicide is the ultimate result of an individual acting upon the negative thought process. Research demonstrates that how a person thinks is predictive of how the person behaves. When a person takes his or her life, the person is acting out the will of the anti-self. The therapist's challenge is to understand this division in a suicidal person, and develop and support the real self of the person and identify the intents of the *voice*. This therapy enables the patient to reconnect and strengthen the real self and rediscover the natural desire to survive. A close and trusting relationship, between therapist and a suicidal patient is an important one to establish to

uncover any hidden intents of the patient (Firestone and Seiden 32-33; Firestone et al., *Self Under Siege* 2).

Not all suicidal patients relay suicidal ideation to clinicians prior to their suicide attempts. A majority of patients act impulsively and only ten percent tell others or leave a note prior to suicide attempts. They may be quite cautious about revealing the full truth, for a large part of them still want to die. Many will hide their real intent or even their method of choice to end their life. If a patient is asked directly about suicide intent, then hopefully a direct and truthful answer is always given. Yet, this is not necessarily the case. *Equation of Suicidal Intent* accurately conceptualizes the real suicidal intent of a patient: Real Suicidal Intent = Stated Intent (what the patient directly tells the clinician) + Reflected Intent (amount of thinking, planning, or actions taken on suicidal ideation that may reflect on the intent) + Withheld Intent (unconsciously or purposefully withheld). A patient's real suicidal or actual intent may equal his stated intent, reflected intent, and withheld intent. It can also be any one of these three, or any combination of the three intents. (Shea, "Assessment Part 1" 3; Shea, "Assessment Part 2" 1; Hall et al. 19).

These are some reasons why a patient purposely withholds suicidal ideations and the method of choice in completing the act. The patient did not want the attempt to be thwarted. The patient feels that suicide is a sign of weakness, shame, immoral, a sin, taboo, and perceived as crazy. The patient fears police appearance or incarceration during a crisis call. The patient fears that others will gain knowledge of suicidal ideations, believes that no one can help, or has alexithymia (Mays 367-72; Shea, "Assessment Part 1" 2-3).

A team of nine expert clinician-researchers conducted a case study on improving clinical interactions between mental health workers and suicidal patients. The purpose was to find the truth in attempted suicides. In a typical thirty-minute or less assessment, the patients typically felt that they had been impersonally processed and given little opportunity to contribute on what really happened. "The working group agreed that current mental health practice often does not take into account the subjective experience of patients attempting suicide, and that contemporary clinical assessments of suicidal behaviors are more clinician-centered than patient-centered" (Michel et al. 424- 25). These nine experts argued for the suicidal person that the patients' stories of frustration and disappointment with important life goals should be shared, as the sharing is instrumental in reestablishing their broken sense of self. Suicidal persons have a tendency to withdraw because they are very vulnerable. Experience suggests that they are more open right after a suicidal attempt. The nine colleagues explained, "Suicide is not merely a matter of the immediate present. Neither does it have a simple cause. It is the culmination of life events and it has a developmental history. Suicide is understood as a possible solution to a subjectively unbearable situation when identity-goals, the achievement of which are essential to the patient's emotional integrity, are frustrated and appear impossible" (Michel et al. 429-30, 435).

Back in the 1970s, suicide survivors became a major voice that began to change and define the fields of suicidality (Jobes et al., *In the Wake of Suicide* 536-61). In 2014, a new voice came through members of the American Association of Suicidology who identified as attempted suicidal survivors. They acknowledged their own experiences of suffering through suicidal attempts. This new voice of the suicidal survivor is powerful.

The voice gives a new perspective on suicide prevention to help the population who struggles with the risk of suicide. Many argue that mental health care experiences were coercive, controlling, humiliating, shaming, and even punishing. Suicide survivors are speaking difficult truths about mental health care and the treatment of suicidal risk (Jobes and Linehan 164). Importantly, the stigma of suicidal ideations must be removed, and the voice of the suicidal survivor heard. Expert clinicians state that one of the reasons that patients violate more than honor their agreements is that, perhaps, they cannot make meaningful commitments to remove suicide *forever* as an option while they are in intense psychological pain and prior to establishing meaningful therapeutic relationships (Rudd et al., "Case Against No-Suicide" 247).

Melvin Lansky discusses further insight about shame found in suicidal persons. He argues that shame is the emotion signaling threat to significant social bonding and is often hidden by depression, guilt, anger, or nonspecific psychic pain. He says, "Suicidal persons become flooded with shame if optimal distance to supportive persons is not maintained and the patient feels overregulated, abandoned or exposed as incapable of sustaining meaningful attachments. Shame dynamics in current familial functioning or dysfunction should be clarified for effective clinical intervention" (230).

David Lester and John F. Gunn III discuss the suicidal theories of Henry Murray, Aaron Beck, and Edwin Shneidman. Understanding suicide is critical in prevention. Lester argues that the following theories are crucial in understanding suicide and recognizing the suicide warning signs and risk factors for suicidal prevention:

- Suicide is associated with depression and hopelessness.
- Hopelessness appears to be the critical factor in the suicide and seen as the only possible solution to a hopeless and unsolvable problem.

- The suicidal person sees the future as negative, expecting more sufferings and frustrations.
- The suicidal person views himself/herself as negative, incompetent, helpless, self-blames, and reproaches against oneself.
- The suicidal person views himself/herself as deprived, alone, unwanted, and unloved.
- Although suicidal thoughts seem arbitrary, the suicidal person considers them valid and sees no alternatives.
- The suicidal person's thinking is characterized by possible errors, so gross as to constitute distortion, like overgeneralization and catastrophizing.
- The suicidal person's emotional reaction aligns with the labeling of the traumatic situation.
- The suicidal person, not wanting to tolerate pain, desires to escape by death which is seen as more desirable than life.
- The act of suicide abolishes painful tension and relief from suffering.
- The suicide is related to unsatisfied or frustrated needs; a lack of achievement or affiliation.
- These emotional states are evident: forlornness, deprivation, distress, blaming others, anger, hate, physical aggression, and grief.
- There is evidence of historical painful antecedents that affect the individual in his/her current situation. These emotional states are evident: blaming oneself, remorse, guilt, bad conscience, depression, and the need for punishment.
- There is evidence for the suicidal person's intent to depart from distress or desert a beloved.
- A state of withdrawal or emotional dissociation is evident with everything seeming meaningless and purposeless. (Lester 656, 660-64)

Nineteen-year-old Kevin Hines jumped off the Golden State Bridge in 2000 and survived his fall. He wrote a book where he tells revealing stories of his personal struggles with his suicide ideations and his suicidal attempts to end his life. Although Kevin had a psychiatrist, he still kept his innermost feelings hidden from his family and friends. In his book, he discusses numerous moments in his struggles and how he was unable to control the voices telling him to kill himself. He talks about giving his prized possessions away, dropping college classes except for one which he attended on his intended last day of life, and sleeping only six hours in the previous two weeks. Kevin shares his difficulties and struggles with writing his suicide note, and how he finally

settled on a version to leave his family. Kevin searched the internet and found websites that told how a person can commit completed suicides, dependent on where one lives. Kevin's choice to jump off the bridge was a guarantee for terminating his life, according to the website, and he made plans to do just that (Hines 46, 48-50).

Kevin helps the reader to understand how he battled between his *other self* that wanted help and his *self* that felt he deserved to die. He says that he believed that he *had* to die. Kevin states, "I want someone to sense my despair. I hoped that one of them would sense my pain and my need for recognition. On the outside, I was holding it together until the bitter end, behavior all too common for suicidal individuals who tend to make some kind of inner pact that lets us back out from the worst decision of our lives" (58). After Kevin jumped off the bridge, falling about two hundred twenty feet at a speed of seventy-five miles an hour, he said to himself,

> What have I done? I don't want to die. God, please save me! There are no words for the pain. It was unimaginable. The night before, I read that I would die upon impact. I did not know that I would be the twenty-sixth person to survive from a list of over two thousand who had permanently made their exits into the afterlife by jumping off the Golden Gate Bridge. (Hines 60, 62)

After this horrific encounter, Kevin continued to be at risk and struggles with suicide.

Even after surviving the fall, Kevin began to have suicidal ideations again. He was suffering from a touch of depression and he started to feel broken again. Classmates found him on the ledge of the window sill of his dorm room that could have resulted in an eight-story jump. Kevin explained that he had suicidal ideations about jumping. He

confessed that he had not asked for help, or followed any type of reputable treatment plan. Therefore, he became suicidal again (88-89).

Dr. Paul G. Quinnett has worked with suicidal people and survivors of suicide for over thirty-five years. In one of his books, *Suicide: The Forever Decision*, Quinnett says:

> One of the reasons I have written this book is that suicide is an unpleasant topic. People do not talk about it. They do not like to hear that about another human being is so troubled that he or she is considering self-destruction. This silence is not good for us. It is my feeling that the more we learn about dying, the more we learn about living. (Quinnett, *Suicide* 2)

Quinnett believes that, for a suicidal person, the state of hopelessness is the most dangerous emotional state a person could be in. "Because without hope is to be despairing of *any* future, of *any* relief, *any* cure, and of *any* promise that things will ever change for the better. It is from this frame of mind, this sense of utter despair, that thoughts of suicide grow strong and robust and take on the shape of an acceptable, if final, solution" (Quinnett, *Suicide* 51). Dr. Quinnett discusses the importance of suicide crisis line numbers for suicidal people. He also asserts that more special training and counseling, especially Clinical Pastoral Counseling on how to work with suicidal people, are needed for clergy (88, 91).

Research Design Literature

This pre-intervention research project used a mixed methods research design. Tim Sensing argues that a research problem is too large, dynamic, and complex for only one single vision and the use of only one single data collection instrument. Multiple angles of vision in a mixed methods research design used by a researcher for collecting

the research data increases the discernment and knowledge of the problem being studied. A mixed methods design with interviews, questionnaires, and surveys provided a record of the participants' perspectives and views, including the legitimacy of their views. These different instruments allowed the researcher to gain greater insight into the participants' thoughts. The inclusive data collected provided a larger representation of the participants' understandings, experiences, and opinions (75-76, 103).

For this research design, two questionnaires, the *Mental Healthcare Staff Best Practices on Suicide Questionnaire* and the *Family and Friends of Suicidal Victims Questionnaire*, were used to collect data for addressing Research Question 1 (RQ1 - "What information and strategies do mental health care clinicians and family members, affected by suicide, indicate should be included in education of early warning signs and support to raise sensitivity?"). The questionnaires were designed by the researcher.

Two surveys, the *Pastoral Education & Knowledge of Suicide Survey* and the *Church Current Suicidal Practices Survey*, were used to collect data for addressing Research Question 2 (RQ2 – "What information and strategies do church leaders and members recommend to be included in an educational ministry for the church in order to raise sensitivity to and awareness of adult suicide through support and prevention?"). The surveys were designed by the researcher.

Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire was used in data collection for this project for addressing Research Question 3 (RQ3 - "What information and strategies do suicidal adults recommend to be included in an educational ministry for churches to raise awareness of adult suicidal behaviors and

recognition of warning signs, so that the church can initiate or improve support and prevention?"). This questionnaire was designed by the researcher.

The qualitative methods used in the data collection for this project were semi-structured interviews from pastors and clergy for addressing RQ2, and from adults free of any suicidal ideations and attempts in the past year for addressing RQ3. The interview questions for the interviews were designed by the researcher.

Summary of Literature

The adult suicidal population has a rising trend, as evidenced by statistics researched and numbers maintained by numerous established entities concerned with the mortality rate of adults by suicide and suicidal attempts. One contributing problem is a lack of awareness of the warning signs of suicide, especially in Kentucky churches. The purpose of this project was to identify and recommend educational materials for churches in the state, to raise awareness of suicidal warning signs, so that local churches can raise sensitivity to the rising trend of suicides among adults through education and support. In spite of the value of community support, no substantial congregation-based programs that target suicide prevention support groups were found. The reviews indicated that this genre of support would provide care and support for people at risk of suicide when they are in transition between clinical visits or when they have missed a scheduled clinical appointment.

Jesus Christ ministered to those who struggled with issues throughout his ministry. He loved and brought healing to those with issues. Statistics show that as suicide has become one of the top causes of death in the United States, with rates rising across the country, healing is urgently needed. Faith leaders are needed to provide spiritual

perspectives and interventions for people at risk of suicide and for the victim's family and friends. The task may appear too difficult and it may take a lot of time, but Jesus never encountered those hurting and in need that he did not take the time to reach out to them and give help. If churches wait until the suicide occurs, then it is just too late to help those who have killed themselves! The church that provides proactive ministries of education, resources, and support groups will have a greater chance to save lives. Jesus said, "You shall love your neighbor as yourself. There is no other commandment greater than these" (Mark 12:31).

Experts argue that formal education of clergy does not prepare them to engage with people at risk of suicide. A study by Lifeway Research that focused on pastor and churchgoer views regarding suicide reported that very few people at risk of suicide talk to their church communities about their personal struggles. Additionally, only 14 percent of churchgoers report that their churches provide training and resources for ministry leaders to be able to even identify signs of someone at risk of committing suicide in the previous year. Churches need to be much more willing to acknowledge and destigmatize the presence of mental health issues and suicides in their faith communities. Suggestions were made that churches could use their facilities to host training seminars to better equip members on how to identify and be a friend to those with mental illness.

It is important to clarify that this does not require church leaders to have a Ph.D. in Clinical Psychology. It simply means pastors must be intentional about equipping themselves and their members to be good neighbors, locate helpful resources, and promote participation among the congregation in suicide awareness. Pastors, chaplains, and pastoral counselors are gatekeepers who identify people at risk and connect them to

other professionals. They also provide spiritual care to suicidal people at all risk levels because other professionals do not typically provide this support. QPR was suggested as an easy-to-learn assessment training for faith leaders and churchgoers to recognize warning signs of persons at risk of suicide. *Question* a person about suicide, *Persuade* the person to get help, and *Refer* the person to the appropriate resource. QPR is a way that can help curb the rising trend of suicide attempts and completed suicides, a way to save lives. Literature reviews support the contention that the church is a viable Christian-based foundation to be explored and expanded as a teaching platform from the pulpit to the pew for suicide prevention.

Published surveys and experienced scholars on the subject matter of suicide have proven the rising trend of adult suicide, not only in our nation, but also in the state of Kentucky. Suicide support groups, outside of clinician visits or hospital stays for adults who are at risk of committing suicide, are lacking. Evidence obtained from reliable resources during research bring awareness that clergy and churches are not utilized in suicide training, which this project proposes for use as viable resources for establishing support groups and education for suicide prevention. This literature review created a new perspective for clergy and the church to become trained and involved in helping to curb the rising trend of suicides by becoming sensitive and aware of the warning signs of suicide.

To determine the kind of information that could be included in Christian, church-based suicide prevention and intervention efforts, this project used a mixed methods research design. Expert informants completed questionnaires to give their strategies and opinions on what should be included in a suicide educational program for churches, so

the church could raise sensitivity and awareness to counter the rising trend of suicides among adults through support and prevention. In addition, suicidal adults, with no suicidal ideations in the past year, participated in individual interviews. Participants shared information and strategies, to be included in training materials for churches, to raise awareness of suicidal behaviors to support adults struggling with suicide. Surveyed church leaders shared information concerning suicide educational ministries currently going on in their churches, and what adult suicide ministries in the church are lacking. Furthermore, this literature review summarizes the salient aspects within the body of knowledge about suicide. The resulting data was used to create a package of best practices and strategies to bring awareness of suicidality to the church and provide Christian-based support and prevention to save lives from suicide intent.

According to the Scriptures, our Christian duty is to pass on God's love to everyone. Jesus commanded us to love our brothers and sisters regardless of their lifestyle. Jesus said, "This is my commandment, that you love one another as I have loved you. Greater love has no one than this, that someone lay down his life for his friends" (John 15:12-13 ESV). People, struggling with suicide and with any issue, are our friends. Christians need to have conversations about the church, suicide, and mental health. A proactive ministry of the church that aligns with God's love for his people and Jesus' healing ministry is needed to address suicide, a horrific termination of life.

The social stigma of suicide has put a gag on having open and honest conversations about this struggle. Suicide is seen as a weak solution to life's issues. If the churches in their society are intentional about helping our brothers and sisters in the struggle, this show of love and support could have a positive impact to help them in their

struggles. Safe places in the church would become an important development to hold conversations surrounding suicide prevention, as an outreach to families and those struggling with thoughts and behaviors of suicide. John Wesley's ministry of healing can continue through our mission work and our faith work by love provided for our suicidal brothers and sisters.

The theologies of love, healing, and hope will lay the foundation of Christian support for the recovery of those struggling with suicide. They can regain their place and worth in society and not be looked upon as a forgotten population. Support groups created in our churches and safe places in our communities can socially diminish the shame, guilt, and embarrassment of suicide, and encourage self-worth, self-love, and self-care. The awareness of suicidal struggles can provide an environment for people to reach out for education and help instead of hiding and denying their suicidal ideations and behaviors. Also, sermons and messages from the pulpits can communicate awareness of the rising trend of adult suicides that can bring the topic into conversations among people. Conversations about suicide would become an important tool for educating and reaching people struggling with mental health illnesses in a large venue other than a medical platform.

The local church and her leaders are lagging behind national efforts to offer a safe place for suicide prevention and intervention in order to decrease the number of suicides and suicide attempts among our adult population. When equipped with accurate information about suicide and armed with strategies for early intervention, the church can become a refuge for those who bear the unbearable burden of suicidal ideation dealing with physical pain disability, mental anguish, loneliness, failure, and social abuses.

Surrounded by a loving, knowledgeable Christian community, and promoted by church leaders, the local church can become a center for emotional and spiritual hope and healing to those who struggle with suicidal ideation and intent because prevention is key to begin this life-saving process. As Jesus healed those with afflictions, churches can be healing places for a miraculous metamorphosis from suicidal adults to self-harm-free people.

CHAPTER 3

RESEARCH METHODOLOGY FOR THE PROJECT

Overview of the Chapter

Chapter 3 covers the research methodology used in this research study. It reviews the nature and purpose of the project, the ministry and cultural contexts, and the project's research questions. A mixed methods approach using research instruments designed by the researcher are identified and explained in relationship to the project's research questions. Participants, data collection, and analysis are described in detail.

Nature and Purpose of the Project

The purpose of this project was to identify and recommend suicide education concerning early warning signs and support in churches, among adults in Kentucky, in order to raise sensitivity and awareness of adult suicide in local churches. Suicide is a growing phenomenon among the adult population. The local church and her leaders are lagging behind national efforts to offer a safe place for suicide prevention and

intervention in order to decrease the number of suicides and suicide attempts among our adult population. Church leaders and members, equipped with accurate information about suicide and armed with strategies for early intervention, can create a safe church environment, a refuge for those who bear the unbearable burden of suicidal ideation. Surrounded by a loving, knowledgeable Christian community, and promoted by church leaders, the local church can become a center for emotional and spiritual hope and healing to those who struggle with suicidal ideation and intent because prevention is key to beginning this life-saving process. As Jesus healed those with afflictions, churches can provide ministries in an effort to help heal and curb the rising trend of suicides among our adults in Kentucky. The church ministries can support safe places for a miraculous metamorphosis of the suicidal adult into a self-harm-free person.

Research Questions

Research Question #1

What information and strategies do mental health care clinicians and family members affected by suicide indicate should be included in education of early warning signs and support to raise sensitivity?

The instruments used to collect data for this research question were completed Questionnaires from Mental Health Care Workers and Family Members who have been affected by victims of suicide. Questionnaires used the quantitative method to gather suggestions to open-ended questions on best practices and preventions of suicide, obtained from mental healthcare staff and family member(s) of suicide victims. The two questionnaires, the *Mental Healthcare Staff Best Practices on Suicide Questionnaire* and the *Family and Friends of Suicidal Victims Questionnaire,* used to collect data addressed

the purpose statement and Research Question 1 of the project. These two questionnaires are attached as Appendix A and Appendix B, respectively. The questionnaires were designed by the researcher and expertly reviewed by my dissertation coach and a licensed mental health therapist.

Research Question #2

What information and strategies do church leaders and members recommend to be included in an educational ministry for the church in order to raise sensitivity to and awareness of adult suicide through support and prevention?

The instruments used to collect data for this research question were completed surveys from church leaders and pastoral and clergy interviews. The *Pastoral Education & Knowledge of Suicide Survey* was used to determine the knowledge and education levels of the pastor church leaders on how to identify and minister to people at risk of suicide. The *Church Current Suicidal Practices Survey* determined training and support practices currently ministered by their churches. These surveys provided quantitative data and were analyzed to identify clergy academic growth and training materials needed to raise awareness among church clergy and church members of suicidal warning signs, respectively. These surveys were used to collect data for addressing Research Question 2 (Appendix C and Appendix D). The surveys were designed by the researcher and expertly reviewed by my dissertation coach and a licensed mental health therapist.

The *Pastoral and Clergy Interviews on Suicide* interview questions were concerned with clergy participation and opinions about the best practices and preventions on suicide and how they saw the church's answer to the purpose statement and Research Question 2 (Appendix E). The qualitative and analyzed data from these semi-structured

interviews provided additional answers to the church's posture on ministering to people at risk of suicide. The interview questions were created by the researcher and expertly reviewed by my dissertation coach and a licensed mental health therapist.

Research Question #3

What information and strategies do suicidal adults recommend to be included in an educational ministry for churches to raise awareness of adult suicidal behaviors and recognition of warning signs, so the church can initiate or improve support and prevention?

A questionnaire (a quantitative method of collection data) and semi-structured interviews (a qualitative method of collecting data) served as the instruments used to collect data for Research Question 3. The *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire* and the *Suicidal Adult Interview* questions were used to gather data from adults struggling with suicide. The questionnaire interviews represented the voices of people struggling with suicide who have been self-harm free of suicidal ideations and attempts for at least one year. This data provided information and strategies that should be included in training materials for churches to raise awareness of suicidal behaviors and recognition of warning signs answering the purpose statement and Research Question 3 of the project. The questionnaire and the interview questions were created by the researcher and expertly reviewed by my dissertation coach and a licensed mental health therapist (Appendix F and Appendix G).

Ministry Context(s)

In the state of Kentucky, The American Foundation for Suicide Prevention's 2018 Suicide Facts and Figures by state reported that on average one person dies by suicide

every 12 hours. Kentucky placed 20th in a suicide ranking of all the states in the United States of America. Suicide is the 11th cause of death in Kentucky; more than twice as many people die by suicide annually in Kentucky than by homicide. The rate per 100,000 population is 16.79, which computes to 756 deaths by suicide out of every 100,000 people ("Suicide Facts & Figures: 2018"). More specifically, the Kentucky Cabinet for Health and Family Services/Department for Behavioral Health, Developmental, and Intellectual Disabilities (BH/DID) reported that in the past decade, an average of 669 Kentucky citizens died by suicide annually. Using 2017 data, BH/DID reported that more than three times as many people die by suicide annually in Kentucky than die by homicide, and Kentucky's suicide death rate is the sixteenth highest in the nation. They are in agreement with other sources that suicide is the eleventh leading cause of death overall in Kentucky. Suicide is the second leading cause of death for ages 10–34, and the fourth leading cause of death for ages 35–44. Suicide disproportionately affects Kentucky's senior citizens. Suicide is the ninth leading cause of death for ages 44-54 and the sixteenth leading cause of death for ages 65 and older ("Suicide Prevention Program").

Participants

Criteria for Selection

One population invited to participate was adult men and women, eighteen years old and older, who suffered from suicidal ideations, intents, or attempts. My research sample, of a population with a mindset of suicide, who experienced suicidal ideations, intents, or behaviors in the past, but had been completely free from any suicidal ideations or suicide intents for a minimum of one year. Family members of suicide victims, Church

Leaders, and Mental Health professionals were the three groups of suicide experts; they were included in my research sample through their experience with the suicidal population. I limited the number of my sample size from ten to twenty persons for each of these three groups. The state of Kentucky, USA represented the geographic location for all my sample groups. I approached Baptist and Non-denominational church congregations that together have over five thousand diverse members. One church was urban and one was much more rural. I created surveys, questionnaires, and interview questions appropriate to each identified group of participants.

The two groups of church participants invited to participate in the research came from different areas of Kentucky and different social-economic locales. One church was in an urban area of the poorest zip code in the county and in the western part of Kentucky. The other church was in a rural/city area in the eastern part of Kentucky. The urban megachurch had over five thousand people, in Louisville, Kentucky, consisting of predominately African-American members. Located in the poorest zip code of Jefferson County and led by an African-American Senior Pastor, the church's denomination was Baptist. The non-denominational church, of approximately 130 members, in Richmond, Kentucky, consisted of 60% Caucasian and 40% African-American members. The church, located in a rural area outside of the small city of Richmond, was led by an African-American Senior Pastor. Both churches and their clergy, church leaders, and members were invited to participate voluntarily in the questionnaires, surveys, or interviews for this ministry project.

Description of Participants

Volunteer participants invited to participate in the research were adults, eighteen years of age and older. Any participant 17 years of age or younger were disqualified from the research. Age, race/ethnicity, and gender were the demographics used by the participants for self-classification. Age range choices were as follows: 17 years or younger, 18–24 years old, 25–34 years old, 35–44 years old, 45–54 years old. 55–64 years old, 65–74 years old, and 75 years and older. Race/Ethnicity selections were: Black/African American, Hispanic/Latino, White/Caucasian, Native American/American Indian, Asian/Pacific Islander, and Other. Male, Female, or Other (specified) was selected. Active participants acknowledged and agreed to an informed consent form.

Interviewed participants were identified by alias names using numerical or alphabetical codes. My research sample for people at risk of suicide consisted of men and women, at least eighteen years of age, who had struggled with suicidal ideations, intents, or behaviors in the past and have been completely free from any suicidal ideations or intents for a minimum of one year. Volunteer participants included family members and friends of persons who had suicidal ideations, suicide attempts, or died from suicide. Mental health professionals who have worked with suicidal clients, and clergy/church leaders active in ministry in the state of Kentucky were participants in the research. Church-member participants were diverse and random across all demographics.

My targeted number of people at risk of suicide were 10 to 20 participants. The targeted number of family members or friends of people at risk of suicide were 10 to 20 participants. The targeted number of mental health professionals were 10 to 20 participants. The target number of clergy/church leaders were 10 to 20 participants. My target number of church members were 50 to 100 participants. The participants were

volunteers across a diverse population who were asked and not coerced by the researcher to participate.

Ethical Considerations

All the data collected was solely for use in my research for this project. No one's name was ever referenced in the write-up of my research. Individuals who participated in semi-structured interviews were coded as interviewee 1, interviewee 2, interviewee 3, etc., with no relatable identification to the person. Consent forms were attached to each research instrument for those persons who agreed to participant and complete the research instrument. Each researcher-designed assessment instrument included consent for data collected through the questionnaires and surveys used in this research. Consent forms were completed prior to interview participation. Only the data of those who signed the consent forms was used in the research.

Before the interview, participants were given a consent form to sign, indicating their understanding of the project and their agreement to be audio-recorded. If the interview was held over the phone, a consent form was emailed or mailed to the participant, signed and sent back to the researcher prior to the interview. The interviewees' names were coded by the researcher to maintain interviewee confidentiality. All research instruments contained consent information that each person agreed upon prior to offering their responses. All responses remained confidential in the reporting of data.

Because suicide is a deeply emotional topic to research, as a Chaplain and ordained minister, I extended an offer to talk confidentially with people at the end of the interviews. For any online research respondent who felt the need for counseling whether they completed the research instrument or not, the National Suicide Prevention Lifeline number, 1-800-273-

8255 (TALK) was made available. I assured participants that the phone line is always open with a trained counselor available to talk with anyone thinking about suicide. Regarding this study, a Full Board Review with Asbury faculty was conducted; both the instruments and the methodology were approved.

Instrumentation

The questionnaires, surveys, and interview questions were designed by the researcher and expertly reviewed by my dissertation coach and two licensed mental health therapists, as well as Asbury Theological Seminary's Institutional Review Board.

Research Question 1

The Mental Healthcare Staff Best Practices on Suicide Questionnaire (MHSQ) and the Family and Friends of Suicidal Victims Questionnaire (FFSVQ) gathered suggestions to open-ended questions on best practices and preventions of suicide, obtained from mental healthcare staff and family member of suicide victims.

Questions 1 and 11 of MHSQ address developing sensitivity to people struggling with suicidal ideations. Questions 2-3, 8, and 11 address knowledge of and resources for prevention and early warning signs of suicide. Questions 4-7 and 9-10 address support and healing for suicidal adults and their families and friends. All questions of MHSQ are aligned to the Purpose Statement and RQ1. Question 1 of FFSVQ addresses developing sensitivity to people struggling with suicidal ideations. Questions 2-4 address knowledge of and resources for prevention and early warning signs of suicide. Questions 5-12 address support and healing for suicidal adults and their families and friends. All questions of FFSVQ are aligned to the Purpose Statement and RQ1.

Research Question 2

The Pastoral Education & Knowledge of Suicide Survey (PEKS) determined the knowledge and educational levels of the church leaders on identification of and ministry to people at risk of suicide. The Pastoral Education & Knowledge of Suicide Survey determined the education and knowledge of the pastor and church leaders. Questions 1, 4-5, and 14-15 of PEKS address education and training for ministering to and counseling a suicidal adult. Questions 2-3, 12, and 17 address developing sensitivity to people struggling with suicidal ideations. Questions 6-7 address knowledge of and resources for prevention and early warning signs of suicide. Questions 8-11, 13, and 16 address support and healing for suicidal adults and their families and friends. All questions of PEKS are aligned to the Purpose Statement and RQ2.

The Church Current Suicidal Practices Survey (CCSPS) determined training and support practices currently ministered by the church. These surveys provided quantitative analysis to identify academic growth and training materials needed to raise awareness of suicidal warning signs among church clergy and church members. Questions 12-13 of CCSPS address education and training for ministering to and counseling a suicidal adult. Questions 1-4 address developing sensitivity to people struggling with suicidal ideations. Questions 5-8 and 14 address knowledge of and resources for prevention and early warning signs of suicide. Questions 9-11 address support and healing for suicidal adults and their families and friends. All questions of CCSPS are aligned to the Purpose Statement and RQ2.

The Pastoral and Clergy Interviews on Suicide (PCIS) interview questions dealt with clergy participants' opinions about the best practices and preventions for suicide and

how they saw the church's answer to the purpose statement. The qualitative analysis of the Pastoral and Clergy Interviews on Suicide also provided answers to the church's posture on ministering to people at risk of suicide. Questions 5-6 and 9 of PCIS address education and training for ministering to and counseling a suicidal adult. Questions 1-2 address developing sensitivity to people struggling with suicidal ideations. Questions 4 and 11 address knowledge of and resources for prevention and early warning signs of suicide. Questions 3, 7-8, and 10 address support and healing for suicidal adults and their families and friends. All questions of PCIS are aligned to the Purpose Statement and RQ2.

Research Question 3

The Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire (ASBQ) and the Suicidal Adult Interview (SAI) questions gathered data from adults struggling with suicide. The interviews and questionnaire represent the voices of people in the struggle of suicide who have been self-harm free of suicidal ideations and attempts for at least one year. This data provided information and strategies that should be included in training materials for churches to raise awareness of suicidal behaviors and recognition of warning signs answering the purpose statement of the project.

Question 5 of ASBQ addresses education and training for ministering to and counseling a suicidal adult. Question 1 addresses developing sensitivity to people struggling with suicidal ideations. Questions 2-3 address knowledge of and resources for prevention and early warning signs of suicide. Questions 4, 6-8 address support and healing for suicidal adults. All questions of ASBQ are aligned to the Purpose Statement

and RQ3. Question 3 of SAI addresses education and training for ministering to and counseling a suicidal adult. Questions 1-2 address developing sensitivity to people struggling with suicidal ideations. Question 4 addresses knowledge of and resources for prevention and early warning signs of suicide. Questions 5-7 address support and healing for suicidal adults. All questions of SAI are aligned to the Purpose Statement and RQ3.

Expert Reviews

The researcher-designed assessment instruments were expertly reviewed by three professionals: Dr. Ellen Marmon, the researcher's dissertation coach and Asbury's Director of the Doctor of Ministry program; Melissa W. Cozart, M.S., L.P.P./Licensed Psychological Practitioner currently employed at Eastern Kentucky University's Counseling Center and a former Director of Counseling at Asbury University; and Yvonne D. Graces, MSSW, LCSW, (Master of Science in Social Work, Licensed Clinical Social Worker.) KY#627; a retired licensed mental health therapist. The reviewers' changes were considered and included in the final versions of the researcher-designed assessment instruments. Verbiage in the questionnaires and surveys was updated to align with the appropriate language used in the mental health field, as requested by Cozart and Graves. Some questions were deleted due to redundancy and open-ended questions were added to capture the opinions and suggestions of the survey respondents, as suggested by Dr. Marmon. Suggestions for better clarity were considered and used, as requested and advised by the three expert reviewers. In addition, the research project underwent a "full board review" by Asbury's Institutional Review Board and was approved with minimal recommendations.

Reliability and Validity of Project Design

The reliability of the project design was enhanced through expert reviews. Validity was strengthened by the research tools' alignments with the purpose statement and the research questions.

Data Collection

For this pre-intervention project, I used a mixed methods approach. Both qualitative and quantitative methodologies were important to the success of this project. Data collection derived from purposive samples of the following: selected pastors and church leaders who had at least three years of preaching experience and ministering at a church; church members of a diverse population; mental healthcare workers who have counseled or worked with the suicidal adult population in a healthcare environment; family members and friends that have experienced adults with suicidal ideations or intents, and/or who have attempted or completed suicide; and adults at risk of suicide with at least one year free of suicidal ideations and attempts.

The quantitative surveys and qualitative questionnaires were emailed to at least twenty individuals in each category across the state of Kentucky. The qualitative interviews, held in Kentucky, were led by the researcher with open-ended interview questions designed to ascertain more information and strategies to connect with and add to the data collected from the surveys and questionnaires. The qualitative individual interviews were semi-structured and consisted of descriptive, ideal position, knowledge, and opinion questions. In his book *Qualitative Research*, Tim Sensing states, "Interviews allow people to describe their situations and put words to their interior lives, personal feelings, opinions, and experiences that otherwise are not available to the research by observation" (103). The individual interviews were held in confidence with only the

researcher and the interviewee present. The researcher sought to get more detailed information than what was collected by the questionnaires from this same genre of adults.

Protecting the confidentiality of the research participants was of utmost importance and was obtained through formal consent on Survey Monkey's online research questionnaires and surveys, and by email or letter for individual interviews. Elizabeth A. Curtis and Jonathan Drennan stress the importance of providing strict confidentiality, privacy, and protection so that the research participant can feel safe participating in the ministry project (81). They further advised, "There are two other crucial elements that must be in play to ensure that consent is not only informed but also voluntary – and thus autonomously exercised. The participant must be free from coercion" (79). The data collected becomes biased and skewed if participants are coerced to complete the surveys, questionnaires, and interviews according to what the participants believe is the researcher's viewpoint.

For the online questionnaires and surveys, links to the online Survey Monkey website were emailed to Mental Health clinicians at UofL Health – Peace Hospital. For other research participants, links were provided on websites and social media pages to reach a diverse and random population of participants. Interview participants were invited by the researcher using emails and telephone calls. Due to the 2020 COVID-19 pandemic, no interviews involved physical person-to-person sessions. The researcher conducted interviews with participants by using Facetime, Zoom, or the phone to honor government-regulated social distancing requirements between individuals.

Data Analysis

Tim Sensing recommends the researcher to capture and interpret the data by using categories, patterns, or themes. In analyzing the emerging themes, categories, and patterns from the raw data, he suggests that another person's eyes should also examine the data to reveal any biases. Sensing recommends a multi-methods evaluation approach allowing triangulation (195, 197). He says, "Three analytical frames of reference will emerge from your triangulating the data, namely, the insider's, outsider's and yours [the researcher's]" (197). The three analytical views in referencing the data will agree and disagree, converge and diverge, have overlapping themes or patterns, slippages or disconfirming evidences, and omissions or silences (197-98).

I analyzed themes/patterns, slippages/disagreements, and silence/omissions in both the interviews and questionnaires. Audio recordings from the interviews were listened to several times by the researcher to acquire information for the research. Information was derived from the answers, suggestions, and opinions expressed by the family and friends of suicide victims and the church leaders in the local churches. Recommendations and best practices from clinical healthcare staff and educators at venues who serve the adult suicide population were also collected and analyzed.

The *Pastoral Education & Knowledge of Suicide Survey* addressed RQ2. The surveys were reviewed by the researcher to count and compare the number of educated clergies versus those who were not fully trained. Descriptive statistic percentages were computed from the data. The *Church Current Suicidal Practices Survey* addressed RQ2. The surveys were reviewed by the researcher to count and compare the number of suicide-related ministries practiced in the church versus those who have none. The *Pastoral and Clergy Interviews on Suicide* qualitatively analyzed the church's stance on

suicide, the lack of support groups for congregants at risk of suicide, and the need for suicide awareness training for the congregation. The researcher reviewed and explored the interview manuscripts several times to list and notate similar ideas, statements, themes, and categories along with new ideas in regard to their church's training, awareness, and support of a suicidal victim's needs.

The *Mental Healthcare Staff Best Practices on Suicide Questionnaire*, the *Family and Friends of Suicidal Victims Questionnaire*, and the *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire* were quantitatively analyzed for patterns of best practices of information and strategies to support the development of training materials and support for the church, and to learn preventions and heighten the awareness of suicide that was lacking in the church. The researcher reviewed the questionnaires to count and compare recurring answers and note new ideas to support training materials and ministries needed at the church for people at risk of suicide. Qualitatively analyzed data from the *Suicidal Adults Interviews* led to additional information and strategies included in the church's training materials and the support desired that was lacking from the church and church leaders. The researcher reviewed and explored the interview manuscripts several times to list and notate similar ideas, statements, themes, and categories along with new ideas to assist the needs of a suicidal person at risk.

CHAPTER 4

EVIDENCE FOR THE PROJECT

Overview of the Chapter

Suicide is a growing phenomenon among the adult population. The local church and her leaders are lagging behind national efforts to offer a safe place for suicide prevention intervention in order to decrease the number of suicides and suicide attempts among the adult population. The purpose of this research identifies and recommends the need for suicide education of early warning signs and support in local churches of Kentucky, in order to raise sensitivity and awareness of adult suicide.

This chapter describes the participants in the research and their demographics. For each of the three research questions, the chapter presents the quantitative data collected from the surveys and questionnaires and the qualitative data collected from the open-ended questions of the surveys, questionnaires, and interviews. This chapter ends with identifying five major findings from the data collected in this research study.

Participants

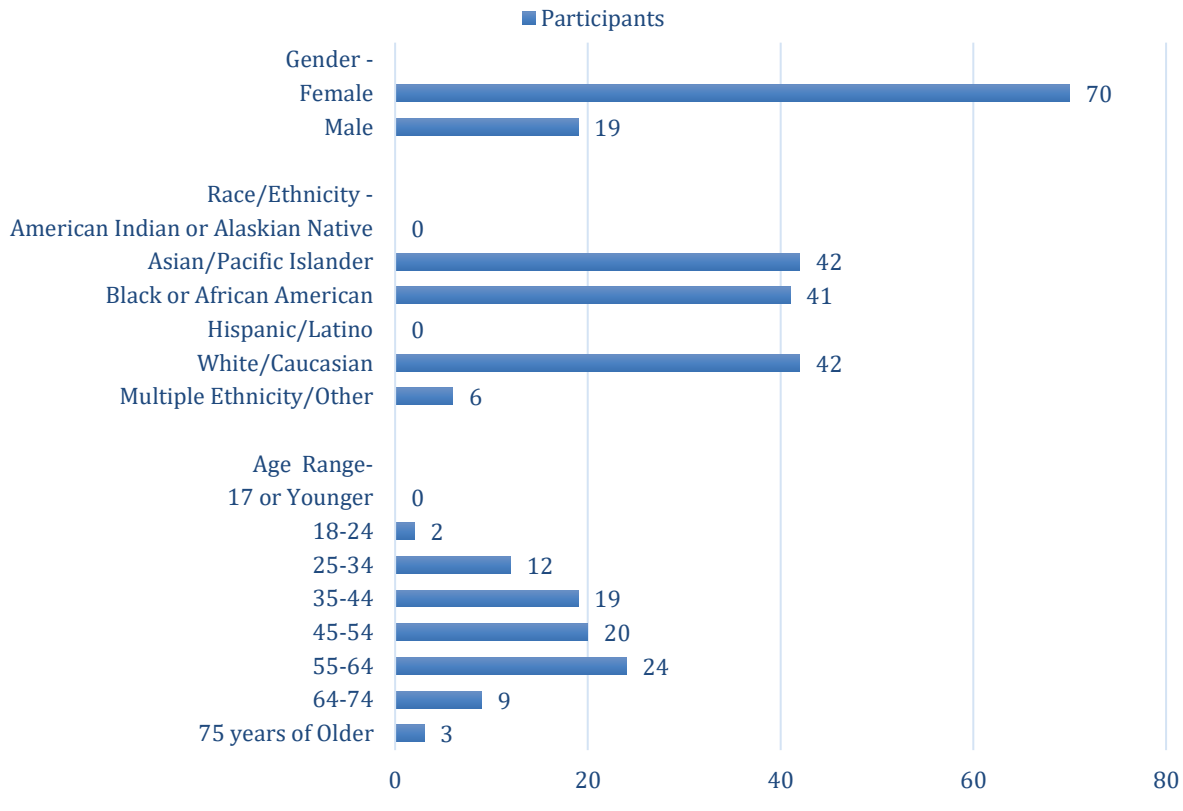
Participants were invited from various social media accounts and website venues due to the 2020 Covid-19 pandemic. Secured Zoom sessions were used for the consented interviews conducted by the researcher. Sixty clergy and church members were invited by email to participate in the research. From the requests for pastoral interviews, three people signed the consent forms (Appendix H) prior to their interviews held privately by the researcher on Zoom. Two participants, through casual conversations about the research, offered to be interviewed by the researcher; they were adults free from suicidal ideations and attempts for at least one year. They also signed consent forms (Appendix I) prior to the researcher's private interview with each of them on Zoom.

Beginning June 2020, the links to Survey Monkey's online surveys and questionnaires were opened and posted on Facebook profiles, requesting participation from audiences. The researcher sent emails numerous times to the UofL Health mental healthcare employees having received permission from the President of UofL Health – Peace Hospital. The researcher posted on her personal LinkedIn profile numerous times. The Executive Director of NAMI Louisville gave the researcher permission to post the research links on their Facebook profile and in their monthly newsletters. The researcher corresponded with the Public Relations & Technology Coordinator of NAMI Louisville during the months of June, July, and August, 2020. The links were posted on Bates Memorial Baptist Church's Facebook profile, Twitter, and Instagram accounts. The links were posted on Lighthouse Church's Facebook profile. The demographics are represented in Figure 4.1. The figure displays the gender, age ranges, and race/ethnicities

of the participants' information gathered from Survey Monkey's online data collectors and the researcher's interviewees.

The survey collectors were closed on November 30, 2020. Due to the nature of social media and how links become buried in profile threads, numerous prompts each month were made to bring awareness to potential participants. Gentle reminders were communicated with the contacts, without coercion for participation, before the links were closed. Out of the eighty-four online Survey Monkey participants, sixty completed the surveys and questionnaires. Added to those completed results, the five interviews

Figure 4.1: Demographics of Participants (N=89)



conducted privately by the researcher, resulted in sixty-five people who participated and completed this research study; participation resulted in 73.03% completion.

Specifically, from the *Mental Health Staff Best Practices on Suicide Questionnaire*, twenty people completed and seven people skipped the questionnaire portion of the research instrument, resulting in 74.07% completion. From the *Family and Friends of Suicidal Victims Questionnaire*, ten people completed and eight people skipped the questionnaire portion of the research instrument, resulting in 55.55% completion. From the *Pastoral Education & Knowledge of Suicide Survey*, seven people completed and one skipped the survey portion of the research instrument, resulting in 87.50% completion. From the *Church Current Suicidal Practices Survey*, twenty people completed and four people skipped the survey portion of the research instrument, resulting in 83.33% completion. From the *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire*, three people completed and four people skipped the survey portion of the research instrument resulting in 42.86% completion.

Research Question #1: Description of Evidence

What information and strategies do mental health care clinicians and family members, affected by suicide, indicate should be included in education of early warning signs and support to raise sensitivity?

The *Mental Healthcare Staff Best Practices on Suicide Questionnaire* (MHSQ) gathered suggestions to open-ended questions on best practices and preventions of suicide, obtained from mental healthcare staff.

- Questions 1 and 11 of MHSQ address developing sensitivity to people struggling with suicidal ideations.

- Questions 2-3, 8, and 11 of MHSQ address knowledge and resources of prevention and early warning signs of suicide.
- Questions 4-7 and 9-10 of MHSQ address support and healing for suicidal adults and their families and friends.

After reviewing the quantitative and mostly qualitative data from this questionnaire, I coded the following major themes repeated by the participants: Established Agencies (blue), Assessment Tools and Awareness Documents (green), Training/Education (pink), Church Support (orange), and Professional Support (purple).

- Addresses - developing sensitivity to people struggling with suicidal ideations:

Question 1: *Do you know of any resources that are helpful in developing sensitivity to people struggling?* From 20 Mental Healthcare Staff:
45% responded "established agencies," 20% responded "training/education," 10% responded types of "assessment tools and awareness documents," and 20% responded "none".

Question 11 - *Is there any information you want to add to the education of church clergy and members in the local church as it pertains to the sensitivity to suicide and awareness of early warning signs of suicide*. From 15 Mental Healthcare Staff:
40% responded "training/education," 20% responded "talk about it," 13.33% responded "need church's influence."

- Addresses - knowledge and resources of prevention and early warning signs of suicide:

Question 2 - *Do you know of any resources that are helpful in educating healthy adults about early warning signs of suicide?* From 20 Mental Healthcare Staff:
45% responded "established agencies," 20% responded "training/education," 10% responded types of "assessment tools and awareness documents," and 20% responded "none."

Question 3 - *What suicide prevention methods/tools do you recommend for churches?* From 19 Mental Healthcare Staff:
47.37% responded "training/education," 47.37% responded "assessment tools and awareness documents," and 10.53% responded "church support."

Question 8 – *Can you name a church facility in Kentucky that offers suicide prevention education?* From 20 Mental Healthcare Staff:

85% responded “No,” 15% responded “Yes,” with 5 churches named.

Question 11 - *Is there any information you want to add to the education of church clergy and members in the local church as it pertains to the sensitivity to suicide and awareness of early warning signs of suicide*. From 15 Mental Healthcare Staff:
40% responded “training/education,” 20% responded “talk about it,” 13.33% responded “need church’s influence.”

- Addresses - support and healing for suicidal adults and their families and friends:

Question 4 - *In what ways do you recommend that church leaders minister and support the adult at risk of suicide?* From 19 Mental Healthcare Staff:
68.42% responded “church support,” 36.84% responded “education,” 36.84% responded “professional support,” 21.05% responded “no shame/no judgement.”

Question 5 - *What resources and support can the church provide for families and friends of adults* ***currently at risk of suicide****?* From 19 Mental Healthcare Staff:
57.89% responded “church support,” 42.11% responded “professional support,” 15.79% responded “established agencies,” 15.79% responded “education,” 5.26% responded “assessment tools,” 5.26% responded “N/A.” The majority said they want the church to have referrals available.

Question 6 - *What resources and support can the church provide for the families and friends of loved-ones who* ***died by suicide****?* From 20 Mental Healthcare Staff:
70% responded “church support,” 35% responded “professional support,” 5% responded “established agencies,” 5% responded “N/A,” The majority said they want support groups in the church.

Question 7 - *What actions and advice should a church avoid when working with suicidal adults?* From 19 Mental Healthcare Staff:
42.11% responded “judgmental/condemning language,” 26.32% responded “shame/blame,” 26.32% responded “just pray, going to hell, a sin, immoral,” 10.53% responded “listen.”

Question 9 - *Can you name a church facility in Kentucky that offers survivors of suicide support groups?* From 20 Mental Healthcare Staff:
15% responded “Yes,” 85% responded “No.” Five churches were named.

Question 10 - *Can you name a church facility in Kentucky that offers survivors of suicide support groups for the families and friends for people who have completed suicide?* From 20 Mental Healthcare Staff:
30% responded “Yes,” 70% responded “No.” Five churches were named.

The *Family and Friends of Suicidal Victims Questionnaire* (FFSVQ)

gathered suggestions to open-ended questions on best practices and preventions of suicide, obtained from family members/friends of suicide victims. Ten family members, seven friends, and one family member and friend started the questionnaire, but only ten people completed it.

- Question 1 of FFSVQ addresses developing sensitivity to people struggling with suicidal ideations.
- Questions 2-4 of FFSVQ address knowledge and resources of prevention and early warning signs of suicide.
- Questions 5-12 of FFSVQ address support and healing for suicidal adults and their families and friends.
- Addresses developing sensitivity to people struggling with suicidal ideations.

Question 1 - *What insight would you provide about being a family member or friend of someone who has suicidal ideations, attempts suicide, or did commit suicide that would benefit the church?* From ten responses:

90% responded "church support through counseling," 10% responded "understanding it is a different grief."

- Addresses knowledge and resources of prevention and early warning signs of suicide.

Question 2 - *What suicide prevention methods should the church provide?* From ten responses:

60% responded "church support," 40% responded "education."

Question 3 - *What mental healthcare practices or suicide prevention education do you think the church could provide for adults to prevent suicidal attempts and ideations?* From ten responses:

80% responded "church support and talk," 30% responded "education," 20% responded "professional support."

Question 4 - *Can you name a church facility in Kentucky that offers suicide prevention education for people at risk of suicide?* From nine responses:

22.22% responded "Yes," 77.78% responded "No." Two churches were named .

- Addresses support and healing for suicidal adults and their families and friends.

Question 5 - *Please list the most helpful things people or organizations have done to support the family members and friends of someone who has suicidal ideations, made suicidal attempts, or ended their lives.* From ten responses:

50% responded "church support," 20% responded "education," 10% responded "established agency," 20% responded "nothing."

Question 6 - *Please list some of the worst and/or least helpful things people or organizations have done in dealing with family members and friends of someone who has suicidal ideations, made suicidal attempts, or ended their lives*. From ten responses:

40% responded "ignored/minimizing," 40% responded "hurtful comments," 10% responded "misunderstanding," 10% responded "N/A."

Question 7 - *In what ways do you recommend that churches minister and support the adult at risk of suicide?* From nine responses:

60% responded "church support through counseling and groups," 30% responded "talk about it," 10% responded "hotline within the church."

Question 8 - *What support/resources can the church provide for the families and friends of adults currently at risk of suicide?* From ten responses:

40% responded "established agencies," 40% responded "support with groups and phone calls," 10% responded "education," 10% responded "I don't know."

Question 9 - *What support/resources can the church provide for families and friends of loved-ones who died by suicide?* From ten responses:

40% responded "counseling, referrals to agencies," 30% responded "support groups," 20% responded "sensitivity, understanding, kindness," 10% responded "I don't know."

Question 10 - *Can you name a church facility in Kentucky that offers survivors of suicide support groups for the family member and/or friend?* From nine responses:

11.11% responded "Yes," 88.89% responded "No." One church named.

Question 11 - *What steps have you personally taken to support someone who has suicidal ideations or attempted suicide?* From ten responses:

50% responded "encourage professional counseling," 30% responded "encourage self-love," 20% responded "support with calls, talk and listen."

Question 12 - *Is there anything else you want to tell the church about their ministry regarding suicide?* From nine responses:

22.22% responded "okay to talk about suicide," 22.22% "acknowledge and don't hesitate," 11.11% responded "Not to degrade," 11.11% responded "Suicide is not a sin. It's a desperate act out of intense pain and illness," 11.11% responded "Black community considers mental health an embarrassment or looked upon negatively," 11.11% responded "Church has to partner with organizations that help people with mental issues."

Research Question #2: Description of Evidence

What information and strategies do church leaders and members recommend to be included in an educational ministry for the church in order to raise sensitivity and awareness of adult suicide through support and prevention?

The *Pastoral Education & Knowledge of Suicide Survey* (PEKS) determined the knowledge and education levels of the church leaders on how to identify and minister to people at risk of suicide.

- Questions 1, 4-5, and 14-15 of PEKS address education and training for ministering to and counseling a suicidal adult.
- Questions 2-3, 12, and 17 of PEKS address developing sensitivity to people struggling with suicidal ideations.
- Questions 6-7 of PEKS address knowledge and resources of prevention and early warning signs of suicide.
- Questions 8-11, 13, and 16 of PEKS address support and healing for suicidal adults and their families and friends.
- Addresses education and training for ministering to and counseling a suicidal adult.

50% of the online participants who responded "Yes" to Question 1, formal education/training in how to minister to and counsel suicidal adults, responded that the education/training was in "Pastoral Counseling" course study.

In Table 4.1, Questions 14 and 15 show that one third of the online pastoral participants responded that they had heard of QPR Training, but not one of the participants had been certified in it.

In Table 4.1, Questions 4 and 5 show that 100% of churches do not currently offer education/training for leaders or church members on how to recognize suicidal warning signs, minister to and counsel suicidal adults.

- Addresses developing sensitivity to people struggling with suicidal ideations.

Two of the three participants who responded "yes" to Question 2, in Figure 4.2, responded that documents and training were offered to bring awareness and sensitivity to the topic of suicide, but did not offer information about a sermon or Bible Study at their churches.

In Table 4.1, for Question 3, five of the participants responded on what should be at the church, but there was no mention of what was currently active in the church. To raise sensitivity of the church, four participants requested that there be open discussions, intentional forums, education, and training to learn of the warning signs. Online Participant 5 said, "We need to know how, as leaders, to be able to properly serve individuals who need attention in this area. We can't be strictly biblical, we have to be able to advise, refer, be prepared, etc.".

Question 12 – *Estimate how many people in your church died by suicide last year?* From six responses: 83.33% responded "0" [zero], 16.67% responded "1*." Have you noticed an increase or decrease in the number of completed suicides over the past years?* From six responses: 66.67% responded "Increase," 33.33% responded "Decrease." Participant 5 said, "Hopelessness is compounded with racism and lack of access to mental health services."

Question 17 – *Is there anything else you want the researcher to know about this topic?* From six responses: 66.67% expressed gratitude for pursuing this topic that the church cannot neglect and no longer afford to ignore. Participant 6 said, "I believe suicide is something the church has neglected to address because of the stigmas attached to it. We need to be more about community and checking in with each other."

- Addresses knowledge and resources of prevention and early warning signs of suicide.

In Table 4.1, Questions 6 and 7 show 28.57% of the participants responded with, "Yes." Not one of these affirmative respondents listed the requested suicide prevention information.

Q6 -*Does your church provide suicide prevention information for an adult at risk of suicide?*

Q7 -*Does your church provide suicide prevention information for the families of adults at risk of suicide?*

- Addresses support and healing for suicidal adults and their families and friends.

In Table 4.1, Questions 8, 9, 13, and 16 show 100% of the participants responded that the church has no active support ministries for adults at risk of suicide or for families of adults at risk of suicide. All of the participants responded that the church needs to address the issue of suicide.

Additional data from six participants, who responded "Yes" (85.71%) to

Question 10: *Have you ministered or counseled an adult in your church who is at risk of suicide?*

How many adults did you minister to or counsel last year?

- Participants 1-5 responded: "2, 3, 5, 10, 25, 50-75".

Have you noticed an increase or decrease in the numbers of suicidal adults you have ministered or counseled from prior years? Briefly explain your response."

- Participant 1 and 6 responded, "no increase or decrease."
- Participant 3 responded, "slight increase" due to staying home and loss of income.
- Participant 2 and 4 responded, "decreased."
- Participant 5 responded, "It's difficult to tell. I have ministered to many who have been in dire situations from all walks of life. Not all have admitted/stated suicide. However, many have been in at the end of their emotional rope when I've intervened. I would suspect they may have also been suicidal."

Additional data from five participants, who responded "yes" (71.43%) to Question 11: *Have you ministered or counseled a Family Member or Friend of someone who has had suicidal ideations, suicide attempts, or died by suicide in your church or outside of your church congregation?*

How many family member or friends did you minister to or counsel last year?

- Participants 1- 4 responded: "0, 1, 2, 5."

Have you noticed an increase or decrease, in the numbers of Family/Friends of suicide victims you ministered from prior years? Briefly explain your response."

- Participant 1 and 3 responded, "decreased."
- Participant 4 responded, "no increase or decrease."

Table 4.1
Pastoral Education & Knowledge of Suicide Survey

Q#	QUESTIONS	N=	YES	NO
1	As a church leader, do you have formal education/training in how to minister to and counsel suicidal adults?	7	57.14%	42.86%
2	Have you preached sermons or held a Bible Study at your church bringing awareness and sensitivity to the topic and rising trend of adult suicide?	7	42.86%	57.14%
3	Do you believe people in the church could be sufficiently educated to raise their sensitivity to suicide?	7	100.00%	0.00%

4	Does your church currently offer education/training, for church leaders, on how to recognize suicidal warning signs, minister to and counsel suicidal adults?	7	0.00%	100.00%
5	Does your church currently offer education/training, for church members, on how to recognize the warning signs of a suicide?	7	0.00%	100.00%
6	Does your church provide suicide prevention information for an adult at risk of suicide?	7	28.57%	71.43%
7	Does your church provide suicide prevention information for the families of adults at risk of suicide?	7	28.57%	71.43%
8	Does your church actively provide a support ministry for adults at risk of suicide?	7	0.00%	100.00%
9	Does your church actively provide a support ministry for families of adults at risk of suicide?	7	0.00%	100.00%
10	Have you ministered or counseled an adult in your church who is at risk of suicide?	7	85.71%	14.29%
11	Have you ministered or counseled a Family Member or Friend of someone who has had suicidal ideations, suicidal attempts, or died by suicide in your church or outside of your church congregation?	7	71.43%	28.57%
13	Do you provide a Kentucky Survivors of Suicide (SOS) support group in your church for family members or friends?	6	0.00%	100.00%
14	Have you heard of QPR training?	6	33.33%	66.67%
15	Have you attended and received certification in QPR training?	6	0.00%	100.00%
16	Does the church need to address the issue of suicide?	5	100.00%	0.00%

The qualitative analysis of the *Pastoral and Clergy Interviews on Suicide* (PCIS) interview questions provided answers to the church's posture on ministering to people at risk of suicide.

- Questions 5-6 and 9 of PCIS address education and training for ministering to and counseling a suicidal adult.
- Questions 1-2 of PCIS address developing sensitivity to people struggling with suicidal ideations.
- Questions 4 and 11 of PCIS address knowledge and resources of prevention and early warning signs of suicide.

- Questions 3, 7-8, and 10 of PCIS address support and healing for suicidal adults and their families and friends.

- Addresses education and training for ministering to and counseling a suicidal adult. (Three interview participants: F1, M1, and M2).

Question 5 - *What resources/education do you have readily available for adults at risk of suicide?* F1, M1/66.67% responded "None," M2/33.33% responded "Internet, materials from healthcare workers and agencies."

Question 6 - *What resources/education do you have readily available for the family members and friends of suicidal adults?* F1, M1/66.67% responded "None," M2/33.33% responded "Printed handouts, internet, refer to agencies."

Question 9 - *Are you open to support suicide prevention education and training for church leaders, suicidal adults, and families of suicidal adults in prevention and post-suicidal education at your church?* F1, M1, M2/100% responded "Yes."

- Addresses developing sensitivity to people struggling with suicidal ideations. (Three interview participants: F1, M1, and M2).

Question 1 - *Have you experienced death by suicide by anyone attending your church?* F1, M2/66.67% responded "Yes," M1/33.33% responded "No."

Question 2 – *How many adults during your ministry have you counseled or ministered to who were at risk of suicide?* F1="2," M1="3," M2="50."

- Addresses knowledge and resources of prevention and early warning signs of suicide. (Three interview participants: F1, M1, and M2).

Question 4 - *Do you have the National Suicide Prevention Lifeline number, 1-800-273-8255 (TALK) visibly displayed for members to see?* F1, M1, M2 (100%) responded "No." What suicidal prevention/education information do you have visibly displayed at your church? F1, M1, M2 (/100%) responded "None."

Question 11 - *Is there anything else you would like me to know about your church regarding suicide prevention and survivor support?*

> F1 responded, "I hope you can be a vessel to begin that dialogue. It's very much needed. We have had two suicides. We really need the education and bring the subject matter to the table because we don't talk about it. We have not talked about it. Suicide is a component we look at last as part of congregational care because culturally it's looked at as something we don't do, which statistically is not true."
>
> M1 responded, "During the pandemic, it has aided and heightened levels of depression and suicide tendencies. The church should have a safe place to talk

about it and a lot of ministers are trying to gear sermons for people dealing with mental health issues that the pandemic has brought on."

M2 responded, "Getting closer to roll out a ministry that addresses the needs."

- Addresses support and healing for suicidal adults and their families and friends. (Three interview participants: F1, M1, and M2).

Question 3 - *How many family members or friends of loved-ones who died by suicide have you counseled or ministered during your ministry?* F1="1," M1="0," M2="25."

Question 7 - *Does your church actively provide a ministry or support group for adults at risk of suicide?* F1, M1, M2 (100%) responded "No." M2 added "No, not yet."

If No: What would prevent you from having a ministry for adults at risk of suicide? F1, M1, M2 (66.67%) responded that there is nothing that prevents having this ministry. M2 (33.33%) added that the ministry was closer to rolling it out, in providing educational support and referrals. F1 further responded, "Not a lot of dialogue around it. A stigma attached to it and African-American faith traditions, we refer people to prayer. Pray. Just don't talk about it. Haven't made an effort to make it a priority even after an incident."

Question 8 - *Does your church provide a ministry or support group for families of suicidal adults?* F1, M1, M2 (100% responded "No." M2 added, "No, not yet."

If No: What would prevent you from having a ministry for the family members of suicidal adults? F1, M1 (66.67%) responded "nothing to prevent." F1 further responded "Getting participation might be a struggle because of the perception and stigma attached. We are a people who hold secrets. We are taught not to talk about what goes on inside of our house. Just that fear of stigma would prevent that type of ministry." M2 (33.33%) responded that the ministry would provide assistance to families.

Question 10 - *What are your fears/concerns of developing and supporting a ministry for suicide survivors at your church?*

F1 responded, "The congregants not coming forth, low participation would be a fear; a challenge initially."

M1 responded, "No fear or concern. We have a strong unit of folks to provide counsel to others."

M2 responded, "Only fear, if any fear, that someone will go beyond the church's scope legally or us not getting in touch with an individual or family member in time and something happens."

The *Church Current Suicidal Practices Survey* (CCSPS) determined training and support practices currently ministered by the church. These surveys provided quantitative

analysis to identify academic growth and training materials needed to raise awareness of suicidal warning signs among church clergy and church members.

- Questions 12-13 of CCSPS address education and training for ministering and counseling a suicidal adult.
- Questions 1-4 of CCSPS address developing sensitivity to people struggling with suicidal ideations.
- Questions 5-8, 14 of CCSPS address knowledge and resources of prevention and early warning signs of suicide.
- Questions 9-11 of CCSPS address support and healing for suicidal adults and their families and friends.
- Addresses education and training for ministering to and counseling a suicidal adult.

In Table 4.2, Questions 12 and 13 show 10% of participants heard of QPR training. None of the participants have attended or received certification in QPR training.

- Addresses developing sensitivity to people struggling with suicidal ideations.

In Table 4.2, Questions 1 and 2 show that 25% of the participants have heard sermons preached raising awareness and sensitivity to the rising trend of adult suicide. 10% of participants had a Bible study at their church on the topic of suicide, while 26.32% attended the Bible Study.

Question 3 – *How many people in your church are you aware of who died by suicide?* From eighteen responses: 66.67% responded "0 (zero)," 11.11% responded "1," 5.56% responded "2," 5.56% responded "More than 5," 11.11% responded "Don't know or Unsure."

Question 4 – *Have you noticed an increase or decrease of suicides over the past years?* From eighteen responses: 89.47% responded "Increase," 10.53% responded "Decrease."

- Addresses knowledge and resources of prevention and early warning signs of suicide.

In Table 4.2, Questions 5 - 8 show a low percentage of knowledge and suicide prevention resources in their church. 100% of the participants responded that the 1-800 Lifeline number is not visibly displayed in their church.

Question 14 – *Is there anything else you would like the research to know*? From eleven responses: 45.45% of participants responded that it is important to bring awareness, education, and support in the church. 36.36% responded "No". Participant 5 responded, "The church should be a sanctuary for the hurting with a sympathetic ear and ready warm hug." Participant 10 responded that the study was eye opening and the topic will be raised to the awareness of the church's pastor. Participant 7 responded, "Great research!"

- Addresses support and healing for suicidal adults and their families and friends.

In Table 4.2, Questions 9 - 10 show that 100% of the participants responded that there are no support ministries active in their churches for adults at risk of suicide and for the families and friends of adults currently at risk of suicide. Question 11 shows that 5% of the participants' churches have a SOS support group or ministry; therefore, 95% of the participants' churches do not.

Table 4.2
Church Current Suicidal Practices Survey

Q #	QUESTIONS	N=	YES	NO
1	Have you heard sermons preached at your church raising sensitivity and awareness to the rising trend of adult suicide?	20	25.00%	75.00%
2.A	Has your church offered a Bible study on the topic of suicide?	20	10.00%	90.00%
2.B	If "Yes", did you attend the Bible study?	20	26.32%	78.95%
5	Does your church provide educational training for church members on the warning signs of people at risk of suicide?	20	10.00%	90.00%
6	Does your church provide suicide prevention information for an adult at risk of suicide?	20	15.79%	84.21%
7	Does your church provide suicide prevention information for the families of adults at risk of suicide?	19	10.53%	89.47%
8	Is the National Suicide Prevention Lifeline number, 1-800-273-8255 (TALK) visibly displayed in your church?	20	0.00%	100.00%
9	Does your church actively provide a support ministry for adults at risk of suicide?	18	0.00%	100.00%
10	Does your church actively provide a support ministry for families and friends of adults at risk of suicide?	18	0.00%	100.00%
11	Does your church provide a Kentucky Survivors of Suicide (SOS) support group or ministry for families or friends who died by suicide?	20	5.00%	95.00%

12	Have you heard of QPR training?	20	10.00%	90.00%
13	Have you attended and received certification in QPR training?	20	0.00%	100.00%

Research Question #3: Description of Evidence

What information and strategies do suicidal adults recommend to be included in an educational ministry for churches to raise awareness of adult suicidal behaviors and recognition of warning signs, so the church can initiate or improve support and prevention?

The *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire* (ASBQ) was used to gather data from adults struggling with suicide. The questionnaire represented the voices of people in the struggle of suicide who have been self-harm free of suicidal ideations and attempts for at least one year.

- Question 5 of ASBQ addresses education and training for ministering to and counseling a suicidal adult.
- Question 1 of ASBQ addresses developing sensitivity to people struggling with suicidal ideations.
- Questions 2-3 of ASBQ address knowledge and resources of prevention and early warning signs of suicide.
- Questions 4, 6-8 of ASBQ address support and healing for suicidal adults.
- <u>Addresses education and training for ministering to and counseling a suicidal adult</u>.

<u>Question 5</u> - *Do you feel that the church leaders and members are trained and educated in ministering to and counseling a person at risk of suicide? Please explain your response.* From three responses: 100% of participants responded "No," they have biases and prejudices about suicide, project shame and guilt, and promote that suicide is a mortal sin and a sigma were explained responses given.

- <u>Addresses developing sensitivity to people struggling with suicidal ideations</u>.

Question 1 - *What do you think the church could provide to help raise sensitivity to and awareness of adult suicide?* From 3 responses: 66.67% responded "preaching," 33.33% responded "Not shame or call it a sin."

- ❖ Addresses knowledge and resources of prevention and early warning signs of suicide.

Question 2 - *How can the church improve in helping you when you have suicidal ideations or feel an intent to harm yourself?* From three responses: 100% of participants responded; provide safe places, acceptance and acknowledgment, checking-in, be available, and conversations.

Question 3 - *How could the church help you or other adults prevent or decrease any suicidal attempts and ideations?* From three responses: 100% of participants responded; education, suicide awareness, encouragement, and discussions.

- ❖ Addresses support and healing for suicidal adults.

Question 4 - *In what ways do you suggest the church could minister to and support adults in their struggles with suicide?* From three responses: 66.67% of participants responded; education, provide a safe place to address the struggle, mental health first aid, checking-in, and support services. 33.33% responded, "N/A."

Question 6 - *Share experiences when the church supported you in your struggle with suicide.* From three responses: 100% responded "N/A" or "I never had a church support me in my struggle with suicide."

Question 7 - *Share experiences when the church did not support you in your struggle with suicide.* From three responses: 100.00% of the participants responded that they did not receive support from the church. Participant 1 further responded, "Church treated me like a leper and banned me for my struggle with depression and suicidal ideation, even rebuking me twice in tongues." Participant 2 was ignored and dismissed as God's plan.

Question 8 - *Is there anything else you want to tell the researcher about the church's role in suicide awareness, sensitivity, and support?* From three responses: Participant 1 (33.33%) responded, "Clergy need to be trained pastorally. Embrace such people in love and understanding without stigma. We are not lesser Christians; we are human Christians." Other participants (66.67%) responded, "N/A" or "No."

The qualitative analysis of the *Suicidal Adult Interview* (SAI) questions provided additional data, representing the voice of people in the struggle with suicide. The

interviewee was free from self-harm, suicidal ideations and suicidal attempts for at least one year.

- Question 3 of SAI addresses education and training for ministering to and counseling a suicidal adult.
- Questions 1-2 of SAI address developing sensitivity to people struggling with suicidal ideations.
- Question 4 of SAI addresses knowledge and resources of prevention and early warning signs of suicide.
- Questions 5-7 of SAI address support and healing for suicidal adults.
- Addresses education and training for ministering to and counseling a suicidal adult.
  (Two interview participants: Int1 and Int2)

Question 3 - *Do you feel that your church leaders and members are trained and educated in ministering to and counseling a person at risk of suicide? Please explain your answer.*

Int1 responded, "No, I don't think they are. In the Baptist Church, it's not a strong point. A taboo subject in the Black Church. We don't deal with mental health issues."

Int2 responded, "Some, right now. One half of the clergy talk about it."

- Addresses developing sensitivity to people struggling with suicidal ideations.
  (Two interview participants: Int1 and Int2)

Question 1 - *How can the church help you when you have suicidal ideations or an intent to harm yourself?*

Int1 responded, "Be available at that time; immediately and not later. Have somebody on call".

Int2 responded, "Speak of it in sermons, being non-judgmental. Creating open space to approach the pastor as a safe place."

Question 2 - *Do you feel that the church has been helpful or useful in curbing the rising trend of suicide among adults? Why or why not?*

Int1 responded, "No." "If I called the church tonight, who would answer and be available to me?"

Int2 responded, "No." "Suicide is such a taboo and threatening subject."

- ❖ Addresses knowledge and resources of prevention and early warning signs of suicide.
  (Two interview participants: Int1 and Int2)

Questions 4 - *What could the church provide to minister and counsel you to prevent and decrease your suicidal attempts and ideations?*

Both participants agreed on awareness, education, resources, phone numbers, and preventive measures already in place.

- ❖ Addresses support and healing for suicidal adults.
  (Two interview participants: Int1 and Int2)

Question 5 - *Share favorable experiences when the church supported you in your struggle with suicide.*

Int1 responded "I have never taken it to the church. Just asked them to pray for me." Int1 kept the real reason a secret: "I was depressed or wanting to hurt myself."

Int2 responded "I don't have any."

Question 6 - *Share experiences when you felt the church did not support you in your struggle with suicide.*

Int1 responded that after asking for prayer, there was no follow-up.

Int2 responded that the church's theology was to be happy all the time. "When I was struggling, I was abandoned and banned by the hierarchy and thrown out of the church."

Question 7 - *Is there anything else you want to tell me?*

Int1 responded, "No." Then Int1 reiterated to make sure to have a support system and to have people available 24/7.

Int2 responded that "stupid answers" are not helpful: "just give it to God", "read the Bible", "you're going to hell", and "it's a sin". Int2 passionately expressed, "Intentional or not, the 21st century church are really good at helping people have reason to commit suicide. Love and compassion trumps professional training. Int1 ended by saying, "We should reach out to others sharing the compassion of Christ."

Summary of Major Findings

Major findings have illuminated from the analysis of data gathered from the five online research tools and the five individual interviews. The summary of the major findings is listed here and will be discussed further in Chapter 5.

- Family and friends of adults at risk of suicide want to receive support from their churches through counseling and education.

- Rather than receiving support and help from their churches, adults struggling with depression, suicidal ideations, or suicidal attempts experienced the church as judgmental and ill-prepared to minister to or counsel adults at risk of suicide.
- Mental Healthcare clinicians believe it is essential for churches to have both referral resources of established agencies in the community, and training/education for ministering to an adult at risk of suicide.
- Pastoral and Church Leaders do not have prevention information, education of suicidal warning signs/QPR training certifications, or active support ministries for adults at risk of suicide or for the family/friends of an adult who is at risk of suicide.

CHAPTER 5

LEARNING REPORT FOR THE PROJECT

Overview of the Chapter

The purpose of this project was to identify and recommend suicide education of early warning signs and support in churches, among adults in Kentucky, in order to raise sensitivity and awareness of adult suicide in local churches. Chapter Five's major findings recommend educational practices for church leaders and Kentucky churches to provide viable spiritual platforms for bringing awareness, support, and prevention education. Safe places in a Christian environment are suggested for people to voice their concerns of suicide, to discuss their hurts and pains, to acquire information and resources, and to seek support and compassion for those at risk of suicide.

Chapter Five provides detailed discussion of the research's four major findings. For each finding, this chapter addresses its alignment with personal observations, the literature review, and biblical/theological perspectives. Ministry implications, limitations of the study, unexpected observations, and recommendations derived from my research study are also discussed.

Major Findings

Family and friends of adults at risk of suicide want to receive support from their churches through counseling and education

Personal Observation

Years ago, I preached the eulogy of a young male adult who committed suicide. He was the son of a very close friend of mine. My friend had a very difficult time with his suicide and did not receive the support of different clergy she sought for comfort and

counseling. She and I often discussed his suicide, but I was not equipped at that time to offer her more than general grief counseling. My research study opened my eyes to how ill-equipped other clergy are to minister to adults at risk of suicide. Clergy generally lack experience and education in counseling, not only the adults struggling with suicide, but also their family members and friends. In Chapter 4, from my online research instruments, a participant pointed out that suicide grief is different from grief suffered from any other death of a loved one. Grief from suicide requires that the church and other supporters have an *understanding that it is a different kind of grief* when counseling those who suffered the loss of a completed suicide victim.

Literature Review

Along this point, Karen Mason in her book, *Preventing Suicide*, argues that family members need support, as they are the unsung heroes in their suicide prevention work. The friends and family survivors of a suicide incident are not the only ones touched by the suicide. When a suicide occurs, everyone in the faith community is a suicide survivor and may require counseling.

Constance A. Barlow and Heather Coleman discuss how suicide alters the pre-existing relationship between family members and friends of loved ones who completed suicide. Talking about the suicide to confidants outside of the nucleus of family and friends, provide family and friends more freedom and safety when speaking their truths about the suicide. Careless and insensitive comments have been known to cause severed relationships among the survivors. The suicidal death of a loved one is a traumatic bereavement. The trauma destroys previous assumptions that people held about the stability and predictability of their lives prior to the horrific loss. The trauma of a death

by suicide affects the stability of the suicide survivors and realigns their immediate and social relationships as they seek to find meaning after their tragic loss (Barlow and Coleman 195-98).

Biblical/Theological Foundations

A biblical remedy for suicide is found in God's love and Jesus' sacrificial love for everyone, the saint and the sinner. While Paul narrated that God's love is given for us even as sinners, Jesus Christ's greatest love for us was shown by his painful sacrificial death on the cross for each of us. God's love for all of us in the world is proclaimed and evidenced in John's powerful and well-known Scripture, John 3:16, "For God so loved the world, that he gave his only Son, that whoever believes in him should not perish but have eternal life." Romans 5:8 further states, "But God shows his love for us in that while we were still sinners, Christ died for us." Both Scriptures testify to God's steadfast and unconditional love for everyone. The church's counseling and educational support, as requested by the family and friends of an adult at risk of suicide, must be founded on God's love and offered to everyone. God's love found in Psalm 13:2 was described by John Drane as a quiet rest in a divine mother's arms (229). Love like that is what their loved ones struggling with suicide should have a chance to feel and experience from the church. Believers are to have the humility to value others above themselves, like Christ did.

Rather than receiving support and help from their churches, adults struggling with depression, suicidal ideations, or suicidal attempts experienced the church as judgmental and ill-prepared to minister to or counsel adults at risk of suicide.

Personal Observation

My goal was to find out what preventive suicide measures could be put into practice, bring awareness to these practices, and actually determine if they were already being practiced by adults struggling with suicide, any practice with an emphasis on spiritual interventions of the local church. Another goal was to hear the voices and find out what best practices and preventive practices were actually needed by those adults with suicide ideations before their thinking escalated into suicidal attempts.

I captured the points of view of those who were at least one year free of having been in the struggle with suicidal ideations and suicide attempts. I was not sure if I would obtain any data from this population. I was grateful to God and amazed by those who stepped up and became participants for my confidential individual interviews and anonymous online research surveys. My participants were adults who had experienced suicidal ideations in the past and were completely free from any suicidal ideations or intents for a minimum of one year. In asking open-ended questions, I reflect on how their stories collectively shared similar degradations suffered by being negatively judged in their respective churches. These churches silenced the interviewees' voices and kept their needs for counseling and ministry a secret. They hid from the shameful stigma of being suicidal. They stated that the pastors, church leaders, and members in their churches never understood their struggles due to a lack of knowledge and education regarding mental illnesses: depression, suicidal ideations, and suicidal attempts.

Literature Review

The project's literature review aligned with and supported what my research participants voiced in my study. In my literature review, experts stated that, due to

negative attitudes some people received from their churches, within two years of a suicide, at least 80% of survivors either leave the church they were attending, join another church, or stop attending church altogether. Disappointment due to unmet expectations, criticism, or judgmental attitudes and treatment are the most common reasons for suicidal people leaving the church (Mason 17; Biebel and Foster 169). One hundred percent of my research participants said that the church never supported them in their struggles with suicide.

In his book *Cracked, Not Broken: Surviving and Thriving After a Suicide Attempt*, nineteen-year-old Kevin Hines tells how he jumped off the Golden State Bridge and survived his fall. Kevin reveals stories of his personal struggles with suicide ideations and suicidal attempts to end his life. Although Kevin had a psychiatrist, he still kept his innermost feelings hidden from his family and friends. After his jump, he confessed that he stopped asking for help and did not follow any type of reputable treatment plan, which eventually led him to become suicidal again (88-89).

Crucially, the stigma of suicidal ideations must be removed, and the voice of the suicidal survivor heard. Expert clinicians believe that one reason that patients violate more than honor their agreements to stay safe is that, perhaps, they cannot make meaningful commitments. They are unable to make commitments to remove suicide *forever* as an option while they are in intense psychological pain and prior to establishing meaningful therapeutic relationships (Rudd et al., "Case Against No-Suicide" 247). Beth Han et al. conducted a study that estimated the rates of deaths by suicide among adults who attempted suicide in the United States. They concluded that suicide attempters at higher risk can be prevented from becoming completed suicides by providing them

increased access to suicide preventions, intervention efforts, and mental health treatments (Rudd et al., "Case Against No-Suicide" 125).

Biblical/Theological Foundations

In the Bible, Job and Elijah chose to practice great faith in God and survived to live. Trust in a faithful God is what they depended on as they chose life over death. Trusting God is an important spiritual practice that our churches teach, the Bible supports, and is the preferred option to practice in times of despair, hurt, and hopelessness. In their struggle with suicide, people can still find some kind of solace in practicing great faith in God. John Drane argues that no matter how difficult it is to figure out life's toughest experiences, or how hard it is to see God at work, God is there. Those who seek God diligently, experience God ultimately revealed to them (238). Church leaders and members must posture themselves to offer God as a spiritual solution to those struggling with the horrific desires of harming themselves with suicidal intents.

Mental Healthcare clinicians believe it is essential for churches to have both referral resources of established agencies in the community, and training/education for ministering to an adult at risk of suicide

Personal Observation

For over five years, while working as a Chaplain in a psychiatric and addiction recovery hospital, I had a large number of professional encounters with adults who struggled with suicidal ideations and suicide attempts. My daily work fueled my concerns for this fragile suicidal population. I talked with people who escalated to a level of suicide from other problems in their lives. I discovered that suicide is a silent killer and a mental health issue that people are reluctant to disclose or discuss because they feel

embarrassed, helpless, and hopeless. I felt a strong desire to engage the church as a viable and visible platform to provide suicide prevention education and support to curb the rising trend of adult suicides. I included mental healthcare clinicians, as important professional resources, to give advice on how the church can best serve adults at risk of suicide. From my research, Mental Healthcare Clinicians highly believe that it is essential for churches to have available both referral resources of established agencies in the community, and training/education for those ministering to an adult at risk of suicide within spiritual venues.

At UofL Health – Peace Hospital, where I was employed as a Chaplain, I worked as a member of the hospital's very high-profile *Suicide Prevention Top Ten Committee*. We trained our staff with an updated protocol we created for establishing a consistent procedure in assessing and documenting our patients for risks of suicide during their treatment. This procedure enabled doctors, nurses, and management to make decisions that stayed current along with the patient's care for having a suicidal risk (SI) diagnosis. Our assessment tool used the Columbia-Suicide Severity Rate Scale (C-SSRS) documentation which aligned with my research as discussed in my literature review in Chapter 2. C-SSRS, an evidence-supported and low-burden solution, is an assessment documentation tool used by clinicians to determine the suicidal risk of a patient. Mental health training is not required to administer it, so it can be administered by anyone who provides patient care, from chaplains to first responders.

Literature Review

The Action Alliance sought a national strategy to enable better predictions of suicidal risk and use of a more efficient allocation of limited healthcare resources. C-

SSRS became a key component of their strategy for suicide prevention ("Columbia-Suicide Severity"). Even when assessment tools are used, ten psychologists determined that mental health providers are not immune from faulty beliefs about suicide. Their determinations resulted from an empirical and quantitative study (Holm-Denoma et al. 555).

David Jobes and Marsha Linehan believe that:

> Merely understanding the nature of a patient's suicidal struggle may not be enough to clinically prevent suicide, but it is an excellent starting point for life-saving work. Beyond understanding, there is a fundamental requirement to effectively *manage* suicidal risk, both clinically with the patient and within ourselves as providers of care. Suicide is simultaneously complex, contentious, mysterious, terrifying, compelling, seductive, and horrifying – across all cultures and around the world. (xii)

Therefore, it will require more resources than mental healthcare clinicians can give to provide the care needed for people who struggle with suicide. The church's support would be a welcome addition in providing assessment and care for those at risk.

Biblical/Theological Foundations

God wants us to encourage and support each other. Paul proclaims in 1 Corinthians 12:26, that if one part of the body suffers, then all parts of the body suffer; whereas, when one part is honored, then everyone rejoices together. The beauty of this is that the stronger members of the body are charged with caring for the weaker and more vulnerable members (Keefe 31). This care is reflected through the mission work and

patient care that mental healthcare clinicians have been called to perform as their service in each patient's care.

Pastoral and Church Leaders do not have prevention information, education of suicidal warning signs/QPR training certifications, or active support ministries for adults at risk of suicide or for the family/friends of an adult who is at risk of suicide.

Personal Observation

While serving as an associate minister and church member, I never witnessed any spiritual components in the church or in lay counseling provided for people struggling with suicide and associated behaviors. I never heard a sermon or Bible study that addressed suicidal thoughts, mental illness, or the prevention of suicidal ideations escalating into suicide behaviors. Before my research, I had no knowledge of any local preventive suicide ministries or education/training on suicidal warning signs in churches for church leaders or members. In my research, I found that none of my participants had knowledge of any local preventive suicide ministries or education/training on suicidal warning signs in the churches for church leaders or members. The lack of education and resources greatly disturbed me as I encountered many adults at risk of suicide on a daily basis as a chaplain and minister, as they sought empathy and support for their mental illness.

Literature Review

The only survivor support group I found during my literature review was one local group in Louisville, Kentucky. The Survivors of Suicide (SOS) support groups met throughout the state of Kentucky helping only survivors who had lost parents and loved ones to suicide. The Kentucky Cabinet for Health and Family Services support the SOS

groups. My data analysis of the research results from all my participants aligned with my literature review that no group meetings are listed or found anywhere in the state of Kentucky for people who are actually at risk of suicide, to prevent suicide for themselves, or for the family and friends of an adult at risk of suicide ("Suicide Prevention Consortium"). The help currently available is only for the family and friends of someone who has completed suicide, thus survivors for suicide (SOS).

A majority of church member participants have never heard a sermon or attended a Bible study that addressed suicide. Therefore, pastoral and church leaders need to reverse this lack of support and establish suicide prevention information, education of suicidal warning signs, QPR training certifications, and active support ministries at their churches for adults at risk of suicide and for the family/friends of an adult who is at risk of suicide. Sermons addressing suicide and spiritual preventions need to be consistently preached to eliminate the stigma surrounding this silent killer.

The literature review supported the proposition that the church is a viable Christian-based foundation to be explored and expanded as a teaching platform from the pulpit to the pew for suicide prevention. Experts, such as those represented by Lifeway Research, argue that formal education of church leaders do not prepare them to engage with people at risk of suicide. Karen Mason further argues that church leaders can help prevent suicide for their congregations by teaching life and death theology, moral objectives to suicide, theodicy, and how to understand and manage suffering. Church leaders can teach about the issues of suicide and remaining stigma-free whenever people become suicidal, attempt suicide, or die by suicide. Church leaders can teach how to build a life worth living with meaningful belongingness and purpose. They can offer

community where relationship skills are learned and practiced. They can offer a place where those who need support can get it; and partner with others in preventing suicide. Faith leaders are needed to provide spiritual perspectives and interventions for people at risk of suicide and for the victim's family and friends (Mason 18).

Church leaders must teach about the issues of suicide and ways to remain stigma-free whenever people become suicidal, attempt suicide, or die by suicide. Suicide crisis can threaten the loving images of God for someone who loses a loved one to suicide. Intensive and intentional pastoral care from the pastor and congregation of the church is required. Loren Townsend, in "*Suicide: Pastoral Responses",* suggests that pastors can embody the presence of Christ in ministry by listening, imagining changing places with the parishioner, empathizing, and connecting. Emotional recovery from church leaders must become the focus of ongoing pastoral care for the individual or family once the immediate suicide crisis has been managed. Townsend further argues that pastors are the first called to support a family in a suicide emergency. Pastors often are the first to hear suicidal thoughts from parishioners with whom they have established caring and listening relationships. Church leaders are often called to care for individuals or family members after a spouse, parent, or child has unsuccessfully attempted suicide (Townsend 11).

Biblical/Theological Foundations

For pastors and church leaders, preaching a Christian theology of love, healing, and hope can lay the foundation of Christian support for the recovery of those struggling with suicide. Unfortunately, this has not occurred in our churches as shown by the lack of training and education of the participants in the research data analysis. Evidence obtained from reliable resources in the research also brought awareness that clergy and

churches are not utilized in suicide training. No substantial congregational based programs that targeted suicide prevention support groups were found. John Wesley's theology of sickness and healing and Jurgen Moltmann's theological theme of hope are theological concepts that can prove helpful in understanding people with suicidal behaviors.

Jesus, throughout his ministry, over and over again ministered to those who struggled with physical and spiritual health issues. Jesus loved and brought healing to those with issues. Throughout the biblical foundation of our New Testament, love and healing are two important theological themes practiced by Jesus; these practices carry the same importance in church leaders ministering to suicidal people today in our churches. From a theological perspective, Jesus Christ ministered to those who were struggling with issues throughout his ministry. Faith leaders are needed to provide spiritual perspectives and interventions for people at risk of suicide and the victim's family and friends. Philippians 2:1-4 reminds all believers to acquire the attitude and heart of Christ toward others. Jesus said, "You shall love your neighbor as yourself. There is no other commandment greater than these" (Mark 12:31).

Ministry Implications of the Findings

The impact of equipping local churches in Kentucky should provide Christians with the love, healing, and hope needed to support the recovery of those struggling with suicide. They can regain their place and worth in society and not be looked upon as a forgotten population. Support groups created in our churches and safe places in our communities can socially challenge and diminish the stigmas of shame, guilt, and embarrassment of suicide, and encourage self-worth, self-love, and self-care. The

awareness and sensitivity of suicidal struggles can provide an environment for people to reach out for education and help instead of hiding and denying their suicidal ideations and behaviors. Also, sermons and messages from the pulpits can communicate awareness of the rising trend of adult suicide and bring the topic into conversations among people. Conversation about suicide would become an important tool to educate and reach people struggling with mental health illnesses in a large venue, like a church, in addition to a medical platform.

The social stigma of suicide has put a gag on openly talking about this struggle. Suicide is seen as a weak solution to life issues. If the churches in Kentucky are intentional about helping our brothers and sisters in the struggle, this show of love and support could have a positive impact to help those who struggle. Safe places in the church could prove to be an important development to hold conversations surrounding suicide preventions, as an outreach for families, and for those struggling with thoughts and behaviors of suicide. Clinical experts have determined that suicide is preventable. Pastors, church leaders, and church members were open to education and training on the warning signs of suicide and establishing support groups for counseling and ministering to adults at risk of suicide, including the family and friends of adults at risk and loved ones who completed suicides.

Limitations of the Study

Due to the 2020 Covid-19 pandemic, persons were invited to participate through various social media accounts and website venues. Consequently, I was concerned with not knowing how long my invitations remained current on the various social media platforms. I found limitations of keeping my invitations and links visible and current on

the sites, as they would eventually be buried by more current data. A huge majority of the population posted on the internet websites numerous and constant communications concerning work, businesses, school, and personal data because of the pandemic.

Participants appeared to be more comfortable with completing Yes/No questions than with open-ended questions. This research study had a large number of open-ended questions to answer and many of them, along with explanations for Yes/No responses were skipped. With the churches closed to in-person services because of the pandemic, the numbers in terms of participating church leaders and church members were considerably lower than what I had expected.

Unexpected Observations

Family members, friends, and church members were refreshingly honest about the lack of education and training, support groups and sensitivity regarding suicide in the church. Some pastor and church leader participants, however, seemed focused on justifying the lack of education and training, support groups and sensitivity regarding suicide in the church. One church leader participant refused to say that the church did not have adequate resources actively available for suicide prevention education, the suicide hotline number visibly displayed, and ministry support groups. Instead, the participant responded, “Yes, but not yet” when interviewed about actively having any of those resources at the church. The participant responded that the suicide hotline number was in his phone, even though asked if it was visibly displayed at the church.

Recommendations

This research project is important because it has become an urgent matter to bring awareness to the rising number of adult suicides and adult suicide attempts in the state of

Kentucky. I strongly encourage and advise that the following six recommendations for churches be put into practice to help curb the rising trend of suicides among our population of adults struggling with the risk of suicide.

1. It is important that the stigma of suicidal ideations is removed. An intentional effort started in a spiritual-based platform would bring attention to suicide and eliminate the need for hiding it. A Christian environment is a loving platform to combat the rising trend of suicides by bringing awareness and providing support to those struggling with it. To speak healing from suicide from our pulpits and provide education about suicide and its early warning signs would contribute to a better understanding of suicide among the adult population in our church families.

2. Prevention is an important key in beginning this life-saving process. I recommend QPR classes (***Q****uestion* a person about suicide, ***P****ersuade* the person to get help, and ***R****efer* the person to the appropriate resource) as an easy-to-learn assessment education/training tool to teach church leaders and congregations to recognize warning signs of people at risk of suicide. Knowledge of QPR brings awareness of suicidal warning signs that will help save lives. When trained pastors and church congregations are trained and certified through suicide prevention education, they can provide spiritual care to suicidal people at all risk levels. This is important because other healthcare professionals do not typically provide spiritual support.

3. Research showed a greater need to bring awareness of suicidal warning signs to our churches where people gather. If the churches would create suicidal support groups at their locations, then Christian-based environments would become available to fill the gaps of support currently lacking for those who are at risk of suicide. Just as Alcoholics

Anonymous and Narcotics Anonymous have shown to be viable support groups, establishing caring contact groups like Suicide Anonymous support groups in churches would become of great value in preventing suicide and suicide attempts. It is important that the stigma of suicidal ideations be removed. Local churches should establish suicide peer support groups throughout our cities and towns, to help curb the rising trend of suicides and destigmatize it.

4. Literature review supported that the church is a viable Christian-based foundation to be explored and expanded as a teaching platform from the pulpit to the pew for suicide prevention. Supported by my research results and reported through my literature review, I strongly recommend educational practices for church leaders and churches so that they may provide safe places in a Christian environment for people to voice their concerns of suicide, to discuss their hurts and pains, to acquire information and resources, and to seek support and compassion.

5. One hundred percent of my research participants responded that the 1-800 Lifeline number is not visibly displayed in their churches; therefore, I recommend that the National Suicide Prevention Lifeline number, 1-800-273-8255 (TALK), be visibly displayed in churches and reminders about it be announced by pastors and church leaders.

6. I recommend that pastors and church leaders frequent websites for current information on suicide prevention and educational training for recognizing suicidal warning signs, such as QPR training. Recommended websites to browse:

- Kentucky Suicide Prevention Group, https://www.kentuckysuicideprevention.org/become-a-gatekeeper/
- Centers for Disease Control and Prevention, https://www.cdc.gov/vitalsigns/suicide/index.html

- American Foundation for Suicide Prevention, https://afsp.org

In summary, I propose that Kentucky churches provide a viable spiritual platform for bringing awareness, support, and prevention education to raise sensitivity to the rising trend of suicides among our adult population. Based on a lack of Christian-based suicide adult support groups, I highly recommend that churches create and maintain ministry groups, as a means to provide Christian support for adults who are at risk of suicide.

Postscript

My work on this project was a call from God to bring awareness to a vulnerable and forgotten population of his children. I cried so many tears and was heart-struck with much sadness as I read and researched suicide trends, the loss of lives, and the lack of sensitivity devoted to suicide. This mental illness has taken too many lives. I became more aware of victims that struggled with suicide ideations and attempts as children, adolescents, and adults. God's call on my life propelled me to devote study and research to create important recommendations for churches to bring awareness and sensitivity to a growing trend of suicides regardless of age, race, gender, class, and sexuality. This was a personal journey that God led me to walk and a destiny I had to reach. The afflicted and ignored were suffering with suicide before the COVID-19 pandemic in 2020, and I believe many more are suffering in our state currently as the result of the pandemic.

In concluding this project, I have been enriched with academic knowledge that I will use to minister to and counsel people inside and outside of the church. My own awareness has grown and I am excited to share with church leaders and members to open their hearts to those I have encountered at risk of suicide in a chaplaincy capacity over the last five years. I will preach what I have experienced from suicidal adults and what I

learned of this horrific mental illness and how it has affected people. I will preach hope, love, trust, and faith in God as spiritual foundations for those in the struggles of suicide ideations. I will do all I can to diminish the shame, hopelessness, lack of self-love and self-worth that people have experienced.

The burden of shame and hopelessness are still central emotional experiences of those with suicidal ideations. No matter what the cause, the end result is tragic. Shame, despair, dishonor, or imprisonment avoidances in biblical times align with the same feelings of hopelessness and uselessness-found in today's culture, as witnessed by relevant literature and personal experiences obtained from twenty-first century suicidal adults. I want to preach sensitivity that must be shown to those in emotional and mental struggles. Biblical remedies of hope and God's love are based on the confidence and assurance found in Scriptures of hope in the Bible. Psalm 62-5-6 says, "Yes, my soul, find rest in God; my hope comes from him. Truly he is my rock and my salvation; he is my fortress, I will not be shaken." Psalm 33: 20-22 further confirms: "We wait in hope for the Lord; he is our help and our shield. In him our hearts rejoice, for we trust in his holy name. May your unfailing love be with us, Lord, even as we put our hope in you."

The task may appear too difficult and it may take us a lot of time, but we must take Jesus' lead. Jesus never encountered anyone he found hurting and in need that he did not take time to reach out to and give help. If churches wait until the suicide occurs, then it is just too late to help those who have killed themselves! The church that provides proactive ministry of education, resources, and support groups will have a greater chance to save lives. This study is not an evaluation of an existing program. Its intent is to lay

the foundation for program development, which can be evaluated in future research endeavors. Therefore, the purpose of my research was to introduce or increase sensitivity, awareness, and knowledge of recognizing suicide warning signs and ministering to adults who are at risk of suicide.

Appendix A

Mental Healthcare Staff Best Practices on Suicide Questionnaire

This questionnaire is used to collect advice from Mental Healthcare Staff to recommend best practices for churches who want to raise sensitivity and awareness of suicide among adults, in order to offer support and prevention.

By completing this questionnaire, you give your consent to the researcher to have your responses remain confidential and be used for research.

Are you a Mental Healthcare Clinician that has counseled or worked with the suicidal adult population in a healthcare environment?
_____ Yes, please complete the questionnaire.
_____ No, please do not complete the questionnaire.

1. Do you know of any resources that are helpful in developing sensitivity to people struggling with suicidal ideation?
   If so, please share titles, links, authors, programs:
   _____
   _____
2. Do you know of any resources that are helpful in educating healthy adults about early warning signs of suicide?
   If so, please share titles, links, authors, programs:
   _____
   _____
3. What suicide prevention methods/tools do you recommend for churches?
4. In what ways do you recommend that church leaders minister and support the adult at risk of suicide?
5. What resources and support can the church provide for families and friends of adults **currently at risk of suicide**?
6. What resources and support can the church provide for the families and friends of loved-ones who **died by suicide**?
7. What actions and advice should a church avoid when working with suicidal adults?
8. Can you name a church facility in Kentucky that offers suicide prevention education? Select: _____ YES _____ NO
   If YES, please list the church name_____

9. Can you name a church facility in Kentucky that offers survivors of suicide support groups? Select: _____ YES _____ NO
   If YES, please list the church name and city:
   _____

10. Can you name a church facility in Kentucky that offers survivors of suicide support groups for the families and friends for people who have completed suicide?
    Select: _____ YES _____ NO
    If YES, please list the church name and city:
    _____
    _____

11. Is there any information you want to add to the education of church clergy and members in the local church as it pertains to the sensitivity to suicide and awareness of early warning signs of suicide:
    _____
    _____

Appendix B

Family and Friends of Suicidal Victims Questionnaire

This questionnaire is used to collect advice from Family Members and Friends of Suicidal Adults to recommend best practices for churches who want to raise sensitivity and awareness of suicide among adults, in order to offer support and prevention. If responding to these questions triggers any distress, professionals are available to talk with you and offer confidential support. Call National Suicide Prevention Lifeline number: 1-800-273-8255 (TALK).

By completing this questionnaire, you give your consent to the researcher to have your responses remain confidential and be used for research.

Are you a Family Member or Friend that has been affected by an adult that has had suicidal ideations or intents, and/or attempted or completed suicide?
_____ Yes, please complete the questionnaire.
Please indicate: Family Member? _____ Friend? _____
_____ No, please do not complete the questionnaire.

1. What insight would you provide about being a family member or friend of someone who has suicidal ideations, attempts suicide, or did commit suicide that would benefit the church?

2. What suicide prevention methods should the church provide?

3. What mental healthcare practices or suicide prevention education do you think the church could provide for adults to prevent suicidal attempts and ideations?

4. Can you name a church facility in Kentucky that offers suicide prevention education for people at risk of suicide? Select: _____ YES _____ NO
   If YES, please list the church name and city:

5. Please list the most helpful things people or organizations have done to support the family members and friends of someone who has suicidal ideations, made suicidal attempts, or ended their lives.

6. Please list the some of the worst and/or least helpful things people or organizations have done in dealing with family members and friends of someone who has suicidal ideations, made suicidal attempts, or ended their lives.

7. In what ways do you recommend that churches minister and support the adult at risk of suicide?

8. What support/resources can the church provide for the families and friends of adults currently at risk of suicide?

9. What support/resources can the church provide for families and friends of loved-ones who died by suicide?

10. Can you name a church facility in Kentucky that offers survivors of suicide support groups for the family member and/or friend?
    Select: _____ YES _____ NO
    If YES, please list the church name and city:
    _____

11. What steps have you personally taken to support someone who has suicidal ideations or attempted suicide?

12. Is there anything else you want to tell the church about their ministry regarding suicide?

Appendix C

Pastoral Education & Knowledge of Suicide Survey

This survey collects information from Church Leaders in Kentucky to determine if they have education and training on recognizing suicidal warning signs, if there is suicide education for their leaders and members at their church. This survey identifies what ministry and counseling is provided for suicidal adults and survivors of loved-ones who died by suicide, and knowledge of QPR training.

By completing this survey, you give your consent to the researcher to have your responses remain anonymous and confidential, and be used for research.

Do you serve as a Church Leader in Kentucky with at least three years of preaching experience and ministry?

Yes ____, Provide us your title and role in the church_____
and continue the survey, please.
No_____, Stop the survey, please.

1. As a church leader, do you have formal education/training in how to minister and counsel suicidal adults?
   Yes _____ No _____
   If Yes, briefly describe your formal education/training:

2. Have you preached sermons or held a Bible Study at your church bringing awareness and sensitivity to the topic and rising trend of adult suicide?
   Yes ____ No ____
   If Yes, please list what you have offered to bring awareness and sensitivity to the topic of suicide:

3. Do you believe people in the church could be sufficiently educated to raise their sensitivity to suicide?
   Yes _____ No_____
   Please briefly explain your response:

4. Does your church currently offer education/training, for **church leaders,** on how to recognize suicidal warning signs, minister to and counsel suicidal adults?
   Yes _____ No _____
   If Yes, describe the education/training:

5. Does your church currently offer education/training, for **church members**, on how to recognize the warning signs of a suicide?
   Yes _____ No _____
   If Yes, describe the education/training:

6. Does your church provide suicide prevention information for an adult at risk of suicide?
   Yes ____ No____
   If Yes, list the suicide prevention information:

7. Does your church provide suicide prevention information for the families of adults at risk of suicide?
   Yes ____ No____
   If Yes, describe the suicide prevention information that is available:

8. Does your church actively provide a support ministry for adults at risk of suicide?
   Yes ____ No ____
   If Yes, describe the ministry:

9. Does your church actively provide a support ministry for the families of adults at risk of suicide?
   Yes ____ No ____
   If Yes, describe the ministry:

10. Have you ministered or counseled an adult in your church who is at risk of suicide?
    Yes ____ No ____
    If Yes, how many adults did you minister to or counsel last year? _____
    Have you noticed an increase or decrease in the number of suicidal adults you have ministered or counseled from prior years? Briefly explain your response: _____

11. Have you ministered or counseled a Family Member or Friend of someone who has had suicidal ideations, suicidal attempts, or died by suicide in your church or outside of your church congregation?
    Yes ____ No ____
    If Yes, how many family member or friends did you minister to or counsel last year? _____
    Have you noticed an increase or decrease, in the numbers of Family/Friends of suicide victims you ministered, from prior years?
    Briefly explain your response:
    _____

12. Estimate how many people in your church died by suicide last year? - _____
    Have you noticed an increase or decrease in the number of completed suicides over the past years? Briefly explain your response:
    _____

13. Do you provide a Kentucky Survivors of Suicide (SOS) support group in your church for family members or friends?
    Yes ____ No ____

14. Have you heard of QPR training?
    Yes ____ No____

15. Have you attended and received certification in QPR training?
    Yes ____ No____

16. Does the church need to address the issue of suicide?
    Yes ____ Why?
    No _____ Why not?

17. Is there anything else you want the researcher to know about this topic?

Appendix D

Church Current Suicidal Practices Survey

This survey collects information from Church Members in Kentucky whether or not they have suicide prevent education/training themselves, education/training in their church, and if they can recognize suicide warning signs. This survey identifies what ministry and counseling is provided for suicidal adults and survivors of loved-ones who died by suicide, and knowledge of QPR training.

By completing this survey, you give your consent to the researcher to have your responses remain confidential, and be used for research.

If responding to these questions triggers any distress, professional people are available to talk with you and offer confidential support. Call National Suicide Prevention Lifeline number: 1-800-273-8255 (TALK).

1. Have you heard sermons preached at your church raising sensitivity and awareness to the rising trend of adult suicide?
   Yes ____ No ____
2. Has your church offered a Bible study on the topic of suicide?
   Yes ____ No ____
   If Yes, did you attend? Yes ____ No ____
3. Has anyone in your church died by suicide?
   Yes ____ No ____
   If Yes, how many people are you aware of who died by suicide?
   _____
4. Have you noticed an increase or decrease of suicides over the past years?
   Increase ____ Decrease ____
   Please briefly explain:

5. Does your church provide educational training for church members on the warning signs of people at risk of suicide?
   Yes ____ No____

6. Does your church provide suicide prevention information **for an adult** at risk of suicide?
   Yes ____ No____
   If Yes, what suicide prevention information is provided?

7. Does your church provide suicide prevention information **for the families** of adults at risk of suicide?
   Yes ____ No____
   If Yes, what suicide prevention information is provided?

8. Is the National Suicide Prevention Lifeline number, 1-800-273-8255 (TALK) visibly displayed in your church?
   Yes ____ No____

9. Does your church actively provide a support ministry for adults at risk of suicide?
   Yes ____ No ____
   If Yes, briefly describe the ministry provided:

10. Does your church actively provide a support ministry for the families and friends of adults currently at risk of suicide?
    Yes ____ No ____
    If Yes, briefly describe the ministry provided:

11. Does your church provide a Kentucky Survivor of Suicide (SOS) support group or ministry for families and friends who died by suicide?
    Yes ____ No ____

12. Have you heard of QPR training?
    Yes ____ No____

13. Have you attended and received certification in QPR training?
    Yes ____ No____

14. Is there anything else you would like the researcher to know?

Appendix E

Pastoral and Clergy Interviews on Suicide

The interview questions for the pastoral and clergy interviews were asked in order to collect additional information from Church Leaders in Kentucky. The pastors and church leaders have at least three years of preaching experience and ministry. They were asked whether or not they have education/training or ministries in their churches on recognizing warning signs of a suicidal adult, if there is suicide education for their leaders and members at their church. This survey identifies what ministry and counseling is provided for suicidal adults and survivors of loved-ones who died by suicide, and knowledge of QPR training.

A consent form was signed by the interviewee prior to engaging in the interview discussion with the researcher.

1. Have you experienced death by suicide by anyone attending your church?
2. How many adults during your ministry have you counseled or ministered who were at risk of suicide?
3. How many family members or friends of loved-ones who died by suicide have you counseled or ministered during your ministry?
4. Do you have the National Suicide Prevention Lifeline number, 1-800-273-8255 (TALK) visibly displayed for members to see? What suicidal prevention/education information do you have visibly displayed at your church?
5. What resources/education do you have readily available for adults at risk of suicide?
6. What resources/education do you have readily available for the family members and friends of suicidal adults?
7. Does your church actively provide a ministry or support group for adults at risk of suicide?
   Yes ____ No ____
   If, Yes: What does the ministry or support look like?
   If, No: What would prevent you from having a ministry for adults at risk of suicide?
8. Does your church provide a ministry or support group for families of suicidal adults?
   Yes ____ No ____
   If,Yes: What does the ministry or support look like?
   If, No: What would prevent you from having a ministry for the family members of suicidal adults?
9. Are you open to support suicide prevention education and training for church leaders, suicidal adults, and families of suicidal adults in prevention and post-suicidal education at your church?
10. What are your fears/concerns of developing and supporting a ministry for suicide survivors at your church?

11. Is there anything else you would like me to know about your church regarding suicide prevention and survivor support?

Appendix F

Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire

This questionnaire is used to collect advice from adults, who have considered suicide, to recommend best practices for churches to raise the sensitivity and awareness of the rising trend of suicide among adults through support and prevention.

By completing this survey, you give your consent to the researcher to have your responses remain anonymous and confidential, and be used for research.

Are you a suicidal adult (18 years or older) who has been free of any suicidal ideations and attempts in the past year? If responding to these questions triggers any distress, professional people are available to talk with you and offer confidential support. Call National Suicide Prevention Lifeline number: 1-800-273-8255 (TALK).

Choose one:

Yes ___ Please complete the questionnaire only if you responded "Yes" to the above criteria.

No ____ Please **STOP** now.

1. What do you think the church could provide to help raise sensitivity to and awareness of adult suicide?

2. How can the church improve in helping you when you have suicidal ideations or feel an intent to harm yourself?

3. How could the church help you or other adults prevent or decrease any suicidal attempts and ideations?

4. In what ways do you suggest the church could minister to and support adults in their struggles with suicide?

5. Do you feel that the church leaders and members are trained and educated in ministering to and counseling a person at risk of suicide? Please explain your response:

6. Share experiences when the church supported you in your struggle with suicide.

7. Share experiences when the church did not support you in your struggle with suicide.

8. Is there anything else you want to tell the researcher about the church's role in suicide awareness, sensitivity, and support?

Appendix G

Suicidal Adult Interview

The interview questions for each adult at risk of suicide were asked individually in order to collect additional information from discussions on what was recommended as education/training or ministries in the church that would help curb the rising trend of suicide.

The adult (18 years or older), must be free of any suicidal ideations and attempts in the past year. If responding to these questions triggers any distress, professional people are available to talk with you and offer confidential support. Call National Suicide Prevention Lifeline number: 1-800-273-8255 (TALK).

A consent form was signed by the interviewee prior to engaging in the interview discussion with the researcher.

1. How can the church help you when you have suicidal ideations or an intent to harm yourself?

2. Do you feel that the church has been helpful or useful in curbing the rising trend of suicide among adults? Why or why not?

3. Do you feel that your church leaders and members are trained and educated in ministering to and counseling a person at risk of suicide? Please explain your answer:

4. What could the church provide to minister and counsel you to prevent and decrease your suicidal attempts and ideations?

5. Share favorable experiences when the church supported you in your struggle with suicide.

6. Share experiences when you felt the church did not support you in your struggle with suicide.

7. Is there anything else you want to tell me?

Appendix H

INFORMED CONSENT LETTER

Adult Suicide: Church Awareness, Support, and Prevention Education

You are invited to be in a research study being done by Jan Way Rudolph, a doctoral student from Asbury Theological Seminary. You are invited because you are a Church Leader in Kentucky with at least three years of preaching experience and ministry.

If you agree to be in the study, you will be asked to recommend best practices for churches to raise the sensitivity and awareness in order to help curb the rising trend of suicide among adults through support and prevention. There is no payment for participation.

Participation in the interview is confidential and is dependent on specific qualifications to be a research participant. If anyone else is given information about you, they will not know your name. A number or initials will be used instead of your name.

I will be recording the interview. You can refuse to respond to any or all of the questions, and you will be able to withdraw from the process at any time without penalty. If something makes you feel uncomfortable while you are in the study, please tell Jan Way Rudolph. If you decide at any time you do not want to finish the interview, you may stop whenever you want.

You can ask Jan Way Rudolph questions any time about anything in this study and during the interview. Jan can be contacted at jan.rudolph@asburyseminary.edu or 502-640-9080.

Signing this paper means that you have read this or had it read to you, and that you want to be in the study. If you do not want to be in the study, do not sign the paper. Being in the study is up to you, and no one will be mad if you do not sign this paper or even if you change your mind later. You agree that you have been told about this study and why it is being done and what to do.

_____ _____

Signature of Person Agreeing to be in the Study Date Signed

Appendix I

INFORMED CONSENT LETTER

Adult Suicide: Church Awareness, Support, and Prevention Education

You are invited to be in a research study being done by Jan Way Rudolph, a doctoral student from Asbury Theological Seminary. You are invited to be interviewed because you are an adult (18 years or older) who has been free of any suicidal ideations, intents, or attempts in the past year. If responding to any questions during the interview triggers any distress, myself or professionals are available to talk with you and offer confidential support. Call National Suicide Prevention Lifeline number: 1-800-273-8255 (TALK).

If you agree to be in the study, you will be asked to recommend best practices for churches to raise the sensitivity and awareness in order to help curb the rising trend of suicide among adults through support and prevention. There is no payment for participation.

Participation in the interview is confidential and is dependent on specific qualifications to be a research participant. If anyone else is given information about you, they will not know your name. A number or initials will be used instead of your name.

I will be recording the interview. You can refuse to respond to any or all of the questions, and you will be able to withdraw from the process at any time without penalty. If something makes you feel uncomfortable while you are in the study, please tell Jan Way Rudolph. If you decide at any time you do not want to finish the interview, you may stop whenever you want.

You can ask Jan Way Rudolph questions any time about anything in this study and during the interview. Jan can be contacted at jan.rudolph@asburyseminary.edu or 502-640-9080.

Signing this paper means that you have read this or had it read to you, and that you want to be in the study. If you do not want to be in the study, do not sign the paper. Being in the study is up to you, and no one will be mad if you do not sign this paper or even if you change your mind later. You agree that you have been told about this study and why it is being done and what to do.

_____ _____

Signature of Person Agreeing to be in the Study Date Signed

Appendix J

12/14/2019

Dear _____,

I am Doctor of Ministry student at Asbury Theological Seminary. The topic of my dissertation is: *Adult Suicide: Church Awareness, Support, and Prevention Education*. The purpose of this project was *to recommend suicide education of early warning signs and support for adults in order to raise sensitivity and awareness of adult suicide in local Kentucky churches*.

My research questions have been approved by my Dissertation Coach. They are:

> RQ1- What information and strategies do mental health care clinicians and family members affected by suicide indicate should be included in education of early warning signs and support to raise sensitivity?
>
> RQ2- What information and strategies do church leaders and members recommend to be included in an educational ministry for the church in order to raise sensitivity and awareness of adult suicide through support and prevention?
>
> RQ3- What information and strategies do suicidal adults recommend to be included in an educational ministry for churches to raise awareness of adult suicidal behaviors and recognition of warning signs, so the church can initiate or improve support and prevention?

I have seven researcher-designed instruments to collect data that require an expert review. I am in need of expert reviews and I am asking you to serve as one of my expert reviewers.

- *Mental Healthcare Staff Best Practices on Suicide Questionnaire*
- *Family and Friends of Suicidal Victims Questionnaire*
- *Pastoral Education & Knowledge of Suicide Survey*
- *Church Current Suicidal Practices Survey*
- *Pastoral and Clergy Interviews on Suicide*
- *Adult Suicidal Best Practices & Preventions on Suicidal Behaviors Questionnaire*
- *Suicidal Adult Interview*

Please evaluate the attached seven documents using the evaluation forms included. You are certainly free to share any narrative that you wish. Please return your evaluation to me by email at jan.rudolph@asburyseminary.edu by December 31, 2019. Thank you in advance for your assistance.

Please call me if you have any questions or concerns.

Sincerely,

Rev. Jan Way Rudoph, MDiv
Asbury Theological Seminary
DMin Candidate
502-XXX-XXXX (cell)

NAME OF INSTRUMENT_____

Question #	Needed	Not Needed	Clear	Unclear	Suggestion to clarify
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
12					
13					
14					
15					
16					
17					

Review Completed by _____

Signature_____ Date Completed_____

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